IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

vs.

STATE OF GEORGIA,

Defendants.

CIVIL ACTION
NO. 1:16-cv-03088-ELR

VIDEOTAPE DEPOSITION OF

WENDY W. TIEGREEN

Tuesday, June 21, 2022, 9:17 a.m., EST

HELD AT:

Robbins Alloy Belinfante Littlefield LLC
500 14th Street, N.W.
Atlanta, Georgia 30318

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LAURA TAYLOE, ESQUIRE

ALISON EWERS, PARALEGAL

JESSICA BERRY, PARALEGAL

JASON SILLING, VIDEOGRAPHER

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THE VIDEOGRAPHER: This is the video deposition of Wendy Tiegreen, taken in the matter of United States of America versus State of Georgia.

Today's date is June 21st, 2022.

Time on the record is 9:17.

My name is Jason Silling. I'm the videographer.

The court reporter is Wanda Robinson.

Counsel, please introduce yourselves, after which the court reporter will swear in the witness.

MR. HOLKINS: Patrick Holkins for the United States.

MS. COHEN: Frances Cohen for the United States.

MS. HERNANDEZ: Danielle Hernandez for the State of Georgia.

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WENDY W. TIEGREEN,

being duly sworn, was examined and testified as follows:

- - - - - - -

MS. PATEL: Monica Patel with the DBHDD.

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EXAMINATION

BY MR. HOLKINS:

Q Ms. Tiegreen, thank you for coming today. Good morning.

A Good morning.

Q Could you please state and spell your full name for the record.

A Sure. Wendy, W-E-N-D-Y, White, W-H-I-T-E, Tiegreen, T-I-E-G-R-E-E-N.

Q Before we get started, I'm going to run through some instructions, a bit of a roadmap for the day.

So we're going to go I expect most of the day, but we'll take breaks. About every hour and a half at least we'll break.

A Okay.

Q If you need a break earlier than that, let me know. The one request I have is that if a question is pending, that you answer the question before we break.

A Sure.

Q As you know, the deposition is being recorded. We have a stenographer who is taking everything down. We also have a videographer who is filming.

For clarity of the record, it would be great if you could let me finish my question before you start your answer, and also respond audibly with yes, no, as opposed to words like uh-huh, uh-uh.

Is that okay?

A That's good. Thank you. Yes.

Q So I'm going to now show you the first exhibit of the day, which is 136.

All exhibits will be shown electronically today.

I'm going to share my screen and give you an opportunity to control the document. Please let me know once you've reviewed it and I'll ask you a few questions.

MR. HOLKINS: Just give me one second.

(WHEREUPON, Plaintiff's Exhibit-136 was marked for identification.)

BY MR. HOLKINS:

Q I've now given you control of the document. Please take a moment to review it and let me know when you've finished.

(Witness reviews exhibit.)

A I've completed the review.

Q Thank you.

I'm going to take control of the document

back.

Ms. Tiegreen, this is the notice of your deposition in this case; is that correct?

A That is correct.

Q Have you seen this document before?

A Yes, I have.

Q Who showed it to you?

A Danielle Hernandez.

Q I'm guessing that was last week, since this was served last week?

A That was this morning.

Q This morning, okay.

Before you reviewed this notice of deposition this morning, had you heard about this case?

A Yes.

Q And what did you know about this case before this morning?

A I have been a respondent to some interrogatories on behalf of the Department, and then received notice that I would be here today from Danielle and from our team as well, and so that was basically the advance notice.

Q Do you recall which interrogatories -- and these are interrogatories served by the United

States in this litigation; is that right?

A Correct -- let me just say I think. Really, our legal counsel just really puts forth questions to our team, and we as team members respond.

Q Okay. We may talk a little bit more about that in a bit.

What's your understanding of what this litigation is about?

A Basically the generalist understanding that I have is it's about access to supports in the GNETS program.

Q What kind of supports specifically?

A Behavioral health supports.

Q Ms. Tiegreen, are you aware Dante McKay, John Quesenberry, and Stephanie Pearson were all deposed in this matter?

A I'm aware Dante and John Quesenberry were. I was not aware that Dr. Pearson had.

Q And for the record, Dante McKay, John Quesenberry and Stephanie Pearson are all DBHDD employees, correct?

A Yes. They are all colleagues, yes.

Q Did you review the transcripts of any of their depositions in this matter?

A No.

Q Ms. Tiegreen, do you understand that your testimony today is under oath?

A Yes.

Q And do you understand that being under oath means you have an obligation to tell the truth?

A Yes.

Q Is there any reason at all why you cannot testify accurately and truthfully today?

A No.

Q Are you taking any medication or other substance that would interfere with your ability to answer my questions fully and truthfully today?

A No.

Q Have you ever been deposed before?

A It's been many years, but I have been deposed before.

Q Were you deposed as an employee of DBHDD?

A Yes.

Q What was the matter that you were deposed in?

A It was related to provider -- a provider fraud case.

Q Was that a Medicaid fraud issue?

A Yes.

Q Who was the provider?
A I do not even recall.
Q Do you know if it was a Community Service Board?
A It was not a Community Service Board.
Q Okay. Do you recall when this deposition occurred?
A This would have been back in the 2000 oo's at some point. Many, many years ago.
Q Have you ever been a plaintiff or a defendant in a lawsuit?
A No.
Q I'm going to be using some acronyms today. I know this business has lots of acronyms and I want to make sure that we're all on the same page. So I'm going to run through the acronyms and make sure you understand what I'm referring to.
A Uh-hum. (Affirmative.)
Q The first one is "DBHDD." Will you understand that I'm referring to the Georgia Department of Behavioral Health and Developmental Disabilities?
A Yes, I will.
Q And when I use the acronym "DCH," will you understand that I'm referring to the Georgia

Department of Community Health?

A Yes.

Q When I refer to "GaDOE," or "DOE," will you understand I'm referring to the Georgia Department of Education?

A Yes.

Q And when I say "CMO," will you understand I'm referring to Care Management Organizations?

A Yes.

Q And when I say "SED," will you understand that I'm referring to serious emotional disturbances?

A Yes.

Q When I say "DBHDD education setting," what I mean is a public school in Georgia where children with SED and other behavioral health conditions receive instruction in services alongside children who do not have disabilities. Do you understand that?

A I have, I have not heard that acronym before, but I will try to retain it for the purposes of this continued interview process.

Q And if I do ask the question where I'm using the term "general education setting," I'll clarify that's what I mean.

A Thank you.

Q When I use the term "GNETS," will you understand I'm referring to the Georgia Network for Educational and Therapeutic Support?

A Yes.

Q When I use the term "CYF" or "OCYF," will you understand that I'm referring to the Office of Children, Young Adults and Families within DBHDD?

A Yes.

Q When I refer to "COE," will you understand that I am referring to the Georgia State University Center of Excellence?

A Yes.

Q I already used the term "CSB." Will you understand that refers to Community Service Board?

A Yes.

Q And when I refer to "EPSDT," will you understand that it means early periodic screening, diagnosis and treatment?

A Yes.

Q And just "SAMHSA" refers to Substance Abuse and Mental Health Services Administration within the U.S. Department of Health & Human Services, correct?

A Yes.

Q And, finally, "NASMHPD" refers to the National Association of State Mental Health Program Directors, correct?

A Yes.

Q So I'm going to virtually set aside this first exhibit and move on to the next one, which will be 137.

(WHEREUPON, Plaintiff's Exhibit-137 was marked for identification.)

MR. HOLKINS: Give me one second.

BY MR. HOLKINS:

Q So this exhibit has three documents, an email with two attachments. I'm going to show you the email first and then I'll show you the attachments.

Do you see the email on your screen?

A I do.

I'll note for the record that this document was produced by the State of Georgia to the United States. It's marked as GA04295422, and this appears to be an email from you, Ms. Tiegreen, sent in March of 2020 with the subject "Bio/Resume," and it has, as I mentioned, two attachments.

Let me just first confirm, this is an email that you sent, correct?

A I'm moving the camera again. I'm sorry.

Q Let me actually give you control. I'm sorry. It will make it a bit easier.

You have control now.

MS. HERNANDEZ: Is there a way to give two people control at one time?

MR. HOLKINS: I wish. If you need control of a document, let me know and I will give it to you.

MS. HERNANDEZ: Thank you.

A Yes, as far as I can tell, because there's no subject writing. Like I can't tell my style, but clearly it looks like it would have been sent from me.

Q Okay, thank you.

I'm going to take back control, and then also stop sharing this document so I can move on to the first attachment.

I'll note for the record that this document was produced as GA04295423. It was attached to the email that we just discussed.

Ms. Tiegreen, this appears to be a bio for you; is that correct?

A That is correct.

Q I'm going to quickly show you the other

exhibit, which is going to be the real focus for us.

MS. COHEN: You mean the other page of Exhibit 136, Patrick?

MR. HOLKINS: Yes. Sorry. The other attachment.

BY MR. HOLKINS:

Q So this is the second attachment to Exhibit 137. I'll note for the record it was produced as GA04295424.

I am going to give you control of the document, Ms. Tiegreen, and please just take a moment to review it and let me know when you've finished.

You've got control.

(Witness reviews exhibit.)

A My apologies for the time.

Q No, take your time.

A It is -- the system is moving quite slow, so I just want to be sure to --

Q No apologies.

A -- be thorough in the review.

Yes, I recognize this document.

Q Is this document your resume?

A It is the resume, I presume, that was selected at the time. It's updated on a regular

basis.

Q Was this resume accurate as of the time you sent it in March of 2020?

A Yes.

Q I'm going to scroll back up to the top.

On Page 1, under "Related Work Experience," you identify yourself as the Director of Medicaid and Health System Innovation at DBHDD, correct?

A Correct.

Q Is that your current title?

A That is my current title.

Q And you assumed that position in August of 2011, correct?

A Correct.

Q In this role, who do you report to?

A I report to Melissa Spurbeck.

Q What is Ms. Sperbeck's title at DBHDD?

A She is division director of the Division of Strategy, Technology and Performance.

Q Broadly, what is the mandate of the Division of Strategy, Technology and Performance at DBHDD?

A So the division is considered like an enterprise, operations division for the Department.

So we do not assume authority for any of the direct lines of service. So if you think about mental health as a line of service, substance use as a line of service, developmental disabilities, they're offices and division for that. We serve kind of as like a buttress or an adjunct to those teams in supporting those lines of work.

So, for instance, if we need to look at performance related to a specific program, there's a team who would look at the performance of those programs. If there is like a Medicaid negotiation that we need to have with the Department of Community Health, then my office would facilitate that conversation and dialogue.

So it's really like what we call enterprise roles to support the direct lines of service business.

Q And do you have a specific programmatic focus within this office?

A No, I do not.

Q So that would mean that you're doing work on behalf of potentially all of the offices within --

A Yes.

Q -- DBHDD; is that correct?

A Yes, that is correct.
Q And that includes OCYF?
A Yes.
Q I think you mentioned that one of the roles or tasks within this division is reviewing performance; is that accurate?
A Within the division, yes.
Q Within the Department?
A Within the division. When you were asking me the specific role for our -- the division, yes, that is one of them.
Q Understood.
Are you doing performance reviews that are specific to OCYF?
A I don't track that level of detail, so I can't respond to that. Sorry. That's not under my auspices, my office's authority. I'm again like a linear adjunct to that. The division is quite large.
Q I'm just trying to understand. If the role of the Division of Strategy, Technology and Performance is to review performance, whose performance are they reviewing?
A Generally, it's about the contracts that the Department would be entering into and is their

accountability to some of those contracts.

Q Would that include contracts with Apex providers?

A I can't say for sure. I've not looked at any of that specific detail. We have a vast line of business, so I just -- I'm not attuned to what the specific priorities are of that, that small group right now.

Q Do you know who within your office would have knowledge about performance reviews in connection with Apex contracts?

A Well, certainly Melissa Sperbeck would. And then there's a team up underneath her. But I think that would be the best name for accountability.

Q So stepping back from that question, more broadly could you just describe your duties currently in this role as director of Medicaid and Health Systems Innovation?

A Sure. So basically there are what I bucket into kind of three large areas: One, Medicaid. The creation of Medicaid partnerships.

So from DBHDD we do not have role in federal law as a Medicaid authority. The Medicaid agency, the Department of Community Health, holds

that responsibility. And so when we want to implement a program that might have an impact to Medicaid beneficiaries who we serve, then we would work with the Department of Community Health to negotiate the pathway for that, and there are a myriad of Medicaid mechanisms that would facilitate that. So that's one bucket.

The second bucket, Health System Innovation, is really to kind of consider emerging health practices that are beneficial to individual's DBHDD serves and to consider whether or not there might be some development, and then research and commitment to embarking on maybe the creation of a pathway for that innovation.

And then third, in my role just kind of as being around for a really long time, I serve as the editor for the community-based behavioral health provider manual. So the final editor.

So, again, as I indicated, there are lines of business where -- like the Office of Children, Young Adults and Families, if they want to make a policy change in the community-based manual, they propose that and then that information comes through me. It's more of a standardization, single voice writing kind of model for them to then bring that

policy to my office to be sure it comports with the voicing of some of that policy.

Q And to make sure I understand, are you the final reviewer of all changes to the DBHDD program manual?

A I'm the final editor, and that's mediative role, so I don't -- I'm not the final approver, but I will bring together the right parties to be sure that the right policy is decided upon.

Q And is the final approver the Commissioner of DBHDD?

A Actually, not generally for the Behavioral Health Provider Manual. It would be a group of division directors who together would make some of those decisions.

We've never had to raise a policy concern up as high as to the Commissioner generally for that level of administration.

Q Just to make sure I understand, would that be individuals at Monica Johnson's level within DBHDD?

A Monica Johnson, and like, again, Melissa Sperbeck, and there are other leaders that are periodically brought in as well, but generally it's facilitated through those offices.

Q Thank you.

So I'm going to ask you some questions about specific lines in your resume.

A Uh-hum. (Affirmative.)

Q We're still on Page 1. I want to direct you to the first bullet, which reads: "Those for Office of Medicaid Coordination and staff which manage the partnership between the state's Medicaid and Behavioral Health authorities and all related oversight, policy, and financing for these collaborative Medicaid programs."

Do you see that text?

A Yes.

Q What does managing this partnership between the State's Medicaid and behavioral health authorities entail?

A Well, it is dynamic, depending on kind of what the issues of the month or the year are, and so it's variable.

In general, as a standard over the course of many years, and I'll harken back to a statement I made a few moments ago, for instance, if there is a new service line that is generating a lot of research or evidence in the country in terms of a new practice line, our department, as a group

behavioral health experts, may review a service and say there's not really a good Medicaid financing mechanism for this service at this point, let us make a proposal to the Medicaid agency and have then mutual considerations for what might be financing, what might be policy, and what might be the approval pathways for that type of service.

It also includes determining some basic eligibility for those services in terms of like medical necessity criteria and the associated policy. So, for instance, who are the practitioners who are best to deliver this service? What is the rate that would best reimburse this service? What are -- is the best unit of implementation for this particular practice. And then we enter into dialogue with Medicaid about that body of work.

So then subsequently, like -- again, management also would include looking at some use trends. So, for instance, how much individual counseling is used versus physicians assessment. And then the department then also has a lens on provider performance through our Administrative Services Organization, and we allow that group to do some monitoring of, of compliance and quality, and then I also sit in on those dialogues in the event

there's a concern or issue to bring to the Medicaid authority.

Q That was a helpful overview. There's a couple of things I want to dive into a little bit more deeply.

The first is the new financing mechanism -- sorry. Exploring financing mechanisms for, for instance, new service. Would those mechanisms include state plan amendments to the Medicaid State Plan?

A Uh-hum. That's one, yeah. So there's other mechanisms that are identified federally, and we often examine them before we would make a choice whether or not that's a pathway or not. But in general the behavioral health benefit that DBHDD assists Medicaid agency in administering is all done through a state plan amendment.

Q Would Medicaid waivers also be an example of a financing mechanism?

A It would be an example but not one we have for behavioral health.

Q Is that because there are no waivers currently being used by the State for behavioral health services?

A That is correct. In Georgia right now and

it's -- yeah. It's just more difficult to use a waiver for behavioral health, federally.

Q Could you briefly explain why?

A I think I would mostly defer to the Department of Community Health on the why. But basically when you're waiving something, you're waiving institutionalization, and institutionalization has been historically defined as not including behavioral health.

Q Is it fair to say that your office would be involved in any state plan amendments relating to services administered by DBHDD?

A For services administered by DBHDD, yes.

Q That would -- just to be clear, that would be all the services that are identified in the DBHDD manual, correct?

A In the program manual there are several services that are not Medicaid approved. So for those state plan services that are within our manual, then the answer to that is yes.

Q Understood. Thank you for that clarification.

You also mentioned being involved in developing medical necessity criteria and associated policy for new services; is that correct?

A Correct. Uh-hum.

Q Just to make this concrete, would that include the State's Intensive Customized Care Coordination service?

A Yes.

Q So you drafted the medical necessity criteria and associated police --

MR. HOLKINS: Or let me rephrase.

Q Were you involved in drafting the medical necessity criteria and associated policy for IC3?

A Yes. I was part of the team who developed that.

Q And for the record, IC3 refers to Intensive Customized Care Coordination?

A Yes.

Q Thank you.

You also mentioned looking at use trends, correct?

A Correct.

Q Would it be fair to say that means tracking utilization of specific services administered by DBHDD?

A Yes, that is correct.

Q Do you evaluate utilization of the full range -- actually, let me hold on to that. I'm

going to wait so you can see another document to ask that question.

You referenced Administrative Services Organization. Is that The Georgia Collaborative ASO?

A Yes.

Q I believe you testified that the ASO, part of their responsibilities include reviewing provider performance; is that correct?

A They do what's called a quality review that includes aspects of quality as well as some compliance elements.

Q And who defines the parameters of the quality review done by Georgia ASO?

A There's a --

MS. HERNANDEZ: Objection.

Go ahead. You can answer.

A There's a team who pulled together to craft the first instrument when it was rolled out, and then subsequently there is a team in-house who continues to review that.

I'm not a part of that review.

Q Is this a team within DBHDD?

A Correct.

Q And who leads that team?

A Virginia Sizemore under the direction of Melissa Sperbeck.

Q Thank you.

I think you mentioned you sit in on some of the -- some meetings in connection with the Georgia Collaborative ASO; is that correct?

A Correct.

Q What is your role? Can you describe what your role is in those meetings?

A So my role, again, is mostly adjunct in that. I think it's important to denote my office is two staff, so I attend on typically a periodic basis to get trend information on how the providers in general are doing related to their quality reviews.

It gives me a sense of what I may need to interface with the Medicaid agency related to the global performance of the system.

Q Could you provide an example of a trend that emerged from one of these meetings?

A Just give me a minute.

Q Take your time.

A Sure. So, for instance, recently there's been dialogue about electronic medical records and how some companies who provide electronic medical records, their background documentation is not

easily accessible or there's elements that, that aren't as neatly recorded from some of these software programs. So we made some modifications to the provider manual as a result of that to be sure we are getting the highest level of accountability in medical records.

Q Do you know whether the Georgia ASO collaborative is assessing quality of services provided in GNETS programs?

MS. HERNANDEZ: Objection.

You can answer.

A They do a random sampling, and so they are not going into the GNETS programs to look at any program specifically.

The random sampling is based on the consumer information and dates of service. So that's how that's pulled. It's not -- it's not pulled by, let's focus on this particular area, like a GNETS program.

And GNETS is not under DBHDD's authority or role in any way, and therefore we wouldn't even have that as a sampling group in our quality reviews.

Q Just to make sure I understand your testimony, GNETS would be excluded, you expect, from

this sample review performed by Georgia Collaborative ASO?

A They --

MS. HERNANDEZ: Object. You can answer.

A They would not be excluded, because if a young person were to be receiving a service, his or her record might be pulled but it wouldn't be a review of the youth in GNETS, it would be a review of the service which was provided to the youth in GNETS.

Q Understood. So this is a survey built on client level service data?

A Yes.

Q Which is inclusive of services that may have been received by a child enrolled in GNETS?

A Correct.

Q Do you know who is responsible within the Georgia ASO Collaborative for leading these quality reviews?

A Nicole Griep is the director.

Q Could you spell her last name?

A G-R-I-E-P.

Q Have any trends relating to GNETS emerged from these meetings with the Georgia ASO Collaborative that you've sat in on?

A Not that I'm aware of.

Q You mentioned you have two staff working under you; is that correct?

A One. There's two of us in the office. One staff.

Q Who is that person?

A Erica Stinson

Q What is Erica Stinson's title?

A She is a program manager up under me for the office.

Q And since you assumed this role in August of 2011, have you always had just one staff working under you?

A Yes. I was about to say briefly, or less. Yes, just one.

Q One more question on this first bullet and then we'll move on.

Who are your primary counterparts at the Department of Community Health for your work in managing the partnership?

A So our -- like my liaisons at the Department of Community Health.

Up until recently, Catherine Ivy, who is no longer with the DCH. Brian Dowd, Lynette Rhoads, and then there's a myriad of other partners,

depending on the project, right. So it really depends if we're looking at a financing model, I may be working with the financing team briefly, and then moving on to work with folks who may be building IT systems and the like.

So it is diverse, but primarily the points of access have been Brian Dowd, Catherine Ivy, and Lynette Rhoads.

Q How often are you in touch with Brian Dowd?

A Weekly at a minimum.

Q Do you have a standing meeting?

A We have a standing meeting, yes, once a month, on children's issues with the Office of Children, Young Adults and Families, and the Medicaid agency.

Q How often are you in contact with Lynette Rhoads?

A At least twice a month, depending on the month. There, there are ebbs and flows in that contact depending on what projects are emerging.

Q I want to skip to the second bullet, which reads: "Responsible for the Children's Health Insurance Program, Reauthorization Act Grant to achieve. The second sub bullet is Integration in

Development of high-fidelity wraparound into the youth behavioral health system."

Do you see that text?

A I do.

Q Is this reference to high-fidelity wraparound the same thing as IC3?

A High-fidelity wraparound is the practice model. What we named it in Georgia is Incentive Customized Coordination, yes.

Q Could you describe the genesis of high-fidelity wraparound in Georgia?

A So high-fidelity wraparound is -- it's complex. I'm sorry.

It first starts as a philosophy of care where you have -- there's a model of practice where you bring together many partners to coordinate and collaborate on behalf of a young person and his or her family. In order to connect them to a various array of services and supports, which may be in the behavioral health medical model, or it may be in school setting, or it may be interfaced with natural supporters, either churches or community programs.

So it really is about wrapping resources around the child and family in order for he or she to have recovery and wellness. So that's the

philosophy.

The national model which emerged in the late 2000s really was around how -- what is the amount of frequency that comes to bear with that? What are the types of practitioners? What kinds of trainings are necessary then for this program to work best?

That's kind of where the high-fidelity part of wraparound then came together.

And then, of course, in Georgia, and in other states, you can ultimately then take those principles and craft a service design, which may or may not be approved by the Medicaid authority, but in Georgia was designed, created in partnership with the Medicaid agency, submitted to Federal CMS and approved for service delivery.

Q I think I understand how that evolved, but I want to ask you, and please tell me if I'm mistaken.

So it started as a waiver service and it evolved into a state plan amendment; is that accurate?

A It began as a waiver demonstration. So there was not a federal pathway to have a waiver for this type of service. So through CHIPRA there were

some opportunities to have some model design, and prior to that there was a demonstration waiver in the mid-oo's, where there was what was called a PRTF waiver demonstration, which then created that short-term waiver, but that was not reauthorized by Congress. And so our pathway then for the future for that was to create IC3 through a state plan amendment.

Q When did that happen?

A The state plan amendment, 2017.

Q In connection with your work developing the high-fidelity wraparound service in Georgia, did you or your staff perform an assessment of need within the State for the service?

A My office did not. We partnered with the Office of Children, Young Adults and Families and the COE to do some developmental work on that pathway.

Q Could you describe that developmental work?

A Yes, just give me a second to --

Q Take your time?

A -- to harken back.

The CHIPRA grant started in the early teens, so we applied for the grant. The design

process was about really kind of taking the learnings from early developmental work here in Georgia with a couple of providers, a handful of providers, and to kind of study and learn what they had practiced in terms of the, the emerging model of high-fidelity wraparound, and then to take those learnings in partnership with two other states.

So the CHIPRA Reauthorization Grant in Georgia was a tri-state initiative that included Maryland and Wyoming.

So we had a collaborative learning grant, and we then were able to also bring in as a result of that grant national experts on high-fidelity wraparound as well as other states who were exceeding in the practice of high-fidelity wraparound, as well as were achieving some success in having it approved and reimbursed by Medicaid authorities.

Q Do you know if this effort by OCYF and COE determined how many children in the State of Georgia or estimated how many children in the State of Georgia need IC3?

MS. HERNANDEZ: Objection.

You can answer.

A Not that I recollect. We, we did know

from other states that it was a very small in who ended up meeting -- a very small number. Sorry, I want to be clear -- a very small number of youth for whom this would be a target population.

So that was based on their emerging experiences. So, for instance, we actually went to the State of Louisiana and spent some time with them studying an implementation that had occurred just ahead of ours in order to see kind of what the potential volume would be, how they were implementing their practice model and the like. That was the benefit of that grant, to have that learning opportunity.

Q Do you have ongoing responsibilities with respect to IC3 in Georgia?

A Only as a partner to Dante.

Q Dante McKay?

A Dante McKay, correct.

Q And what are your contributions as a partner to Dante McKay with respect to IC3?

A So, for instance, if there, if there is something like a meeting or a quality review team where there's some emerging dialogue or conversation about IC3 and how the providers are managing, how the work is emerging, trends and innovation that are

coming out nationally, he and his team will bring me in to dialogue to just consider was the implementation, what it needed to be initially, is the criteria what it needed to be initially, like any of those questions where there might be dialogue, then he would bring me in almost like as a preparatory process for doing to go back to the Medicaid agency and change any context or consideration for this.

Q Have you had any discussion with Dante McKay about targeting IC3 to students who are enrolled in GNETS?

A No. Not that I recall.

Q I'd like to skip to another bullet in your resume. This is under your current position. It reads: "Steers cross-Departmental initiatives."

It identifies a number of initiatives, including "Coordination of Provider Manuals, Medicaid Systems Design, Administrative Services Organization products."

Do you see that text?

A I do.

Q You talked about the coordination program manuals already. Can you explain what you mean by Medicaid systems design?

A So, for instance, when there is a -- like a new IT roll-out, myself, John Quesenberry, we will come together as like a project team, a temporary project team, to be sure that the new pilot system design still connects with our system, still helps our system function in terms of prior authorization, the registration of individuals, the transaction of prior authorizations from our agency to the Medicaid agency, et cetera.

And then when there are roll-outs, for instance like for the Care Management Organization in Georgia, we are asked for feedback on what our thoughts are. We are not the authority, so we just provide our feedback and influence, and then they can make decisions about whether or not they accept some of that feedback, don't accept that feedback and the like.

So those are two examples I can offer.

Q When you say roll-outs for the Care Management Organizations, what are you referring to?

A Generally like -- there's several parts of that. There's the procurement and design phase, and depending on those events and who is in leadership, there's been a lot of involvement or less involvement, again ebbs and flows in policy and

design.

When, for instance, there are readiness reviews, our agency will -- let me be more clear. I have participated in on the readiness reviews, just to be sure like to sit at the table with the Medicaid agency to say, you know, do they have a website that says that they've served behavioral health and is that kind of a generalist, good generalist language for that.

At any kind of sublevel, in terms of any administrative authority, we don't have that role or functionality. We serve as -- again, I'm going to use this word a lot -- like an adjunct voice related to behavioral health when the Medicaid agency has an interest in, in needing some additional information on that.

Q I believe you testified that your influence over this process ebbs and flows?

A Yes.

Q Depending on leadership?

A Leadership, bandwidth, how much time there is in the day, how much pressure is coming through, in terms of behavioral health changes and dynamics that Medicaid may be considering.

So many factors.

Q How would you describe your level of influence under the current leadership?

A That seems quite subjective. They still -- they call for advice sometimes. Yeah, it just -- that's hard to define. So I'm --

Q When you say "they," are you referring to DCH?

A DCH, yes. Yes, DCH.

So I mean I think they know we're here. They lean in where it's an area where they feel like they don't have a set of expertise. But beyond that, it's -- relationship is imprecise, right. So I'm struggling a little bit with how to, to define that relationship.

Q Well, let's make it concrete.

How many times a month would you say you're consulting with DCH with respect to Care Management Organizations?

A So I -- Dante and myself, we lead a standing once a month meeting on behavioral health issues with the CMOs. So that is a very concrete way where we influence. We set the agenda for that meeting.

It is not necessarily content about how they practice. It is about information sharing for

how the public sector behavioral health system functions as a whole in Georgia.

So, again, I want to give an example, because I think relationship, again it's like a nebulous thing to define.

The State is about to implement a federal law related to using 988 as a new crisis call line, and our department is in charge of that initiative. It will have impact for all Georgia citizens, including those who will be covered by the CMOs. So we've been doing episodic presentations to them since we learned about our role and began the roll-out work for that, so that they are fully informed and aware.

They may or may not change their practice as a result of that information, but we share it.

Another subject that we've had on our agenda quite a bit in the past year is about suicide prevention. So we have the authority to hold the suicide prevention office for the State, and so our suicide prevention director will attend these meetings and share information about emerging, you know, epidemiological numbers and events that we are rolling out. Again, the CMOs then are the recipients of that information, so that we are a

more communicative system but they do not take any direction or lead from us in those dialogues. It's more -- I call it -- it's more about kind of creating global access, collaboration, engagement, across different payors who may have different policy.

Q Is it accurate to say that the CMOs are contractors of the Department of Community Health in Georgia?

A That is correct.

Q So DCH has authority over the CMOs; is that correct?

A Yes.

Q Do you in your capacity at DBHDD ever provide feedback on the contracts between DCH and the CMOs?

A No. Not feedback on the contracts per se. If we hear, for instance, that a young person has certain coverage and there's an access challenge, we'll refer that to the Medicaid agency. But in terms of feedback on the contracts, rarely, if ever.

Q So you wouldn't be shaping the CMOs' responsibilities under the contract with DCH for reimbursing behavioral health services, correct?

A No.

Q The last item listed in this bullet is "design and development of autism benefit."

Do you see that language?

A Yes.

Q Could you describe what autism benefit you're referring to?

A So the State of Georgia created a more robust autism benefit in the mid to late teens, and so I served as chair briefly of the roll-out for the design process.

So in the first year and a half we brought together the Department of Community Health, the Department of Public Health, and DBHDD in a collaboration to roll out what was charged to us by the executive branch in terms of creating a more robust autism benefit.

So we were advisory on some part of that work, and we took some responsibility for a contractor to, but largely non-Medicaid, related to what DBHDD implemented on that work.

Q Did the Georgia Department of Education have any role in the design or roll-out of the autism benefit you just described?

A They were listed kind of as the secondary agency, so Child Welfare, the Department of

Education, and the Department of Juvenile justice were advisory adjunct, understanding that the heavy policy lift and design would come from those three initial agencies.

Q Understood. Who within the Georgia Department of Education was working on the autism benefit?

A At the time -- who advised was I think Garry McGiboney was in one advisory meeting, and anybody else I would have to go back and look up because each agency just brought like a handful of folks, again only periodically in terms of advising that process.

Q Could you describe just operationally what this expanded autism benefit looks like from a service perspective?

A Sure. So the benefit that was created was an outpatient benefit for youth with autism who were Medicaid beneficiaries, and that outpatient benefit was to be administered, and is continued to be administered, by the Department of Community Health.

So we sat again in advisement to the Medicaid agency to contemplate what a good service benefit would look like, and that included services, rates, the units of rates, in terms of design

process. Ultimately, the Department of Community Health then submitted that as a Medicaid State Plan to CMS, which was approved and then implemented.

There were aspects of the plan which were also not identified in what is now called the autism outpatient benefit but was put into what was considered the physicians benefit in terms of doing some screenings and having a process for reimbursing for those screenings in the physicians benefit.

And then kind of the, the third bucket of implementation was specific to some more intensive programs. So, one, there was a PRTF autism benefit created, and so specifically understanding that many youth needed some long-term engagement, longer term residential treatment, that would benefit from a PRTF model. And so that benefit was created, again through the Department of -- excuse me -- Department of Community Health.

We advised that process, but they continued to manage that directly.

And then the other intensive benefits, there was not national evidence on some of the best models for this. So ultimately the State created just some test pilots, implementation models, that DBHDD took responsibility for. So we in turn

contracted for two crisis respite homes for youth with autism and for an autism Crisis Stabilization Unit, which again none of which were crafted to be Medicaid benefits. They were stand-alone state funded benefits, which has not been governed in any way by the Medicaid authority, yet Medicaid youth could access them, but it was not determined at the time for there to be enough kind of clinical evidence on models to take it to be in a full state plan.

Q Thank you very much.

I'd like to go back to the autism outpatient benefit that you were describing.

I think you said there was a state plan amendment in connection with that benefit, correct?

A Yes.

Q Did you draft the state plan amendment for the autism outpatient benefit?

A In partnership with Marcey Alter, who was with the Department of Community Health.

So we collaboratively wrote that.

Q Marcy Altar is no longer with DCH, correct?

A Correct.

Q Is Brian Dowd in the role that Marcy Altar

was previously in?

A I can't say that for sure.

Q That's fine.

A The title was never the same. I think every time someone leaves, they kind of slightly tweak things.

So I liaison with he and Catherine Ivy the way I used to liaison with Marcey Alter.

Q Thank you. That's helpful.

Do the therapies available under the autism outpatient benefit include applied behavioral analysis?

A Applied behavioral analysis is -- I'm going to go back to the high-fidelity wraparound conversation for a minute.

Applied behavioral analysis is a practice. A billable service could be different. So it is a way, for instance, to do specific services.

Like there's 500 ways to do individual therapy. The code is just called individual therapy.

Q Understood.

A So there is a pathway to do applied behavioral analysis through the autism benefit.

Q And be reimbursed for it, correct?

A And be reimbursed for it, correct.

Q Would it also be true for cognitive behavioral analysis?

A I'm not sure about that. I think so but I have not done any analysis of that particular evidence-based practice to contemplate it in, in that path. So sorry.

Q Thank you.

What about functional behavioral assessments, is that a practice that could be reimbursed under the autism outpatient benefit?

A Yes.

Q Is it accurate to say that when a service is added to Georgia's state plan, Medicaid state plan, that there is a requirement to provide that service statewide when medically necessary?

MS. HERNANDEZ: Objection.

You can answer.

A I feel like that's really ultimately the Medicaid authorities to answer, but that has always been my understanding.

MS. HERNANDEZ: Patrick, if we can take a quick five-minute break. If you're still --

MR. HOLKINS: You know what, that's totally fine. We can take five. That's great.

MS. HERNANDEZ: Thank you.

MR. HOLKINS: You're welcome.

THE VIDEOGRAPHER: Off the record at 10:22.

(A recess was taken.)

THE VIDEOGRAPHER: Back on the record at 10:30.

BY MR. HOLKINS:

Q Ms. Tiegreen, we were discussing still your resume, which is Exhibit 137. I have some more questions for you.

First, going back to the DBHDD program manual, is it accurate to say that the authority for designing and defining the services in DBHDD's program manual rests with DBHDD?

A It is -- it is -- it rests with us. However, it is strongly influenced by Medicaid practice parameters and the bounds of some those parameters.

Q Could you describe practically what that means, the influence of Medicaid parameters on DBHDD's program manual?

A So, for instance, Medicaid does not allow billing in a residential setting greater than 16 beds. So you'll see several references throughout

our manual that you can bill Medicaid if it's within these parameters.

So that's a concrete example.

Q That's helpful.

So you're designing services within the boundaries established under Medicaid for receiving reimbursement for the service?

A Correct.

Q And do any other agencies beyond DBHDD have responsibility for designing the behavioral health services in DBHDD's program manual?

A No.

Q Do agencies outside of DBHDD have involvement in designing the services in DBHDD's program manual?

A I would --

MS. HERNANDEZ: Object. Sorry.

You can answer.

A I would just say rarely. I would just say rarely.

If another agency came to us and had some ideas or interest, we would kind of have those dialogues separate and be coordinating and collaborating, but they wouldn't be saying I'm coming to influence the manual.

So we continue great partnerships and we learn together as agencies, but I can't think of an example where that's occurred.

Q Are all of the publicly funded behavioral health services available in Georgia listed in DBHDD's program manual?

A No.

Q There are other services that are funded by the State of Georgia not listed in the manual?

A Correct.

Q Which are those?

A So Medicaid has other program manuals for behavioral health that would not be in our manual. So we already mentioned the autism benefit from PRTF is not in a DBHDD manual. That's a good example.

There's another category of service called Children's Intervention School Supports, not under the purvey in any way of DBHDD.

Q Is the Children's Intervention Support Services under the purview of DCH?

A Yes.

Q Could you describe briefly what the Children's Intervention Support Services are?

Let me just --

A I'd rather not because it's been a long

time since I've looked at the manual. So I just -- I think in a nutshell is, is some basic outpatient services for, for young people who would be a specific age, very, very young. And I can't, I don't -- we don't have purview over that program, so I don't spend a lot of time in that manual.

Q We'll talk a little bit more about this later but I'm trying to understand just broadly whether these are EPSDT services or a different subset of services defined by DCH?

A Medicaid would have to clarify that ultimately, but the federal law is services that are under 21 through 20, you know, or have the EPSDT overlay, but that would be Medicaid's to define and respond to.

Q Does DOE have any involvement --

MR. HOLKINS: Let me rephrase.

Q Has DOE had any involvement, to your knowledge, in shaping service design for DBHDD's program manual?

MS. HERNANDEZ: Objection.

You can answer.

A Not directly. Indirectly, as a partner, like a -- as children's agencies come together and work, for instance, like through the Interagency

Directors Team, we learn together about what needs are. So indirectly those needs could come into shaping the provider manual, but not directly.

Q Can you give an example of a conversation you've had with DOE staff through an IDT meeting, for example, that has shaped services under DBHDD's program manual?

A Certainly. The Department of Education, maybe 2018, 2019, came to us with their student survey data and did a presentation on their student survey data. And then all of us who were in the room, obviously listening to the conversation, then have the lens of what are the needs of young people, how they said they were feeling related to their emotional health. And therefore when I walk out of that room, I don't leave that behind. That is imprinted on me as a policymaker.

I would imagine the same for my partners Dante and Dr. Pearson as well, when we hear that information. But limited to that. That would be the type of dialogue that was occurring.

Q Do you recall whether there were specific changes made to DBHDD's program manual in response to this presentation about students survey -- survey data? Excuse me.

A No, I do not recall any specific related to that.

Q I want to skip down to a prior role that you had that's listed on this resume.

This is on Page 1 still. The resume identifies you as Deputy Chief of Staff from March 2009 to July 2011. Is that correct?

A Correct.

Q The second bullet under that position identifies you as the primary author of the Medicaid State Plan, which includes peer support home health and wellness services with the State of Georgia?

A Correct.

Q We've talked a bit about this already, but for the record it would be helpful if you could describe what it means to be the primary author of the Medicaid State Plan amendment?

A So that means my fingers on the keys. So very, very concretely that.

But with the influence of leaders, such as Dante. So if he says we need this new children's service, then I would work with him in drafting that content, writing that content, and then proposing it to the Department of Community Health, who would be the final kind of arbiter of the language that would

go forward, and that would be with a lot of dialogue and negotiation.

Q Who within DCH is the final arbiter, to use your word, on state plan amendments?

MS. HERNANDEZ: Objection.

You can answer.

A The process in Georgia has been that it goes through the Division of Medicaid, which would be Lynette Rhoads. Ultimately, the Commissioner decides if it goes in front of the Board, and then the Board actually embarks on the process of proposing the state plan amendment, creating the public hearing process for that, and then if approved, then it's submitted to CMS.

Q And when you say "Commissioner," were you referring to the Commissioner of DCH?

A The Commissioner of DCH.

Q And when you said "Board," what did you mean?

A The Board of DCH.

Q Did you consult at all with the Governor's Office when working on the Medicaid State Plan between 2009 and 2011?

A I did not directly.

Q Indirectly?

A So yes, indirectly. It would be -- any time we would have done something as large as a Medicaid State Plan, then our commissioner would have had a dialogue through his or her leadership -- his at the time -- his leadership with the Governor's Office, but I was never privy to that.

Like I would be directed, we have the green light, move ahead, but I was not part of those dialogues.

Q When you said "our commissioner," you're referring to DBHDD's commissioner, correct?

A DBHDD's.

Q Did provider organizations have input on the Medicaid State Plan that you worked on?

A Yes.

Q Could you describe that process?

A Sure. It's largely dependent on the type of service that would be rolled out, but as I indicated earlier, like, for instance, on IC3, we had a handful of providers who were already implementing the model in Georgia. So they came to collaborative meetings where we talked about the model and considered the design that we would ultimately put into a Medicaid State Plan.

So they were part of that, that whole

CHIPRA grant process, in terms of where we -- we actually had money to develop this through that grant. So we had the opportunity to facilitate a lot of robust meetings specific to that.

On other services, we would then bring in niche providers who were skilled at that particular service and have them inform and shape.

Q Did you specifically consult with Community Service Boards during the drafting process for this Medicaid State Plan?

A For -- let's see.

I'm thinking of the years. Just bear with me for one second.

Yes, yes. We worked a lot then, yes, with CSBs. Thank you. I just needed a minute to think through what services were in that Medicaid State Plan and then consider the process and, yes, we worked with several providers on that.

Q I know that peer support is identified in your resume as one of the services under the state plan. What were the other services?

A For instance, we -- and this may not be an exhaustive list, but we added addiction services for peer support during this time frame. We also added more content to the assertive community treatment

service, designating a more rural model for delivery for that.

We split up a service that used to be more globalized in order to be accountable to the Department of Justice, splitting out a service that used to be skills training and case management. We separated those two areas so that we could count case management with more accountability.

That's -- may not be complete but that's about the gist of what we were probably working on during that time frame.

Q Do you have ongoing responsibilities with respect to implementation of the DOJ settlement you just referenced?

A I do not. I do not.

Q And, generally, what was the subject of that settlement, as you understand it?

A The subject of the settlement was to create more community-based alternatives to individuals to prevent them needing services in high end and intensive acute settings so they could remain in the community and have meaningful lives.

Q Was that settlement about services for both youth and adults?

A Adults only.

Q Adults only.

To your knowledge, is the State of Georgia under any settlement currently with respect to youth behavioral health services?

A Not that I am aware of directly. Or that I'm involved with directly. I can't think of either, actually.

Q In your view, have efforts to implement DOJ's settlement with respect to adult mental health services been effective in expanding community-based services for those individuals?

A Yes.

MS. HERNANDEZ: Objection.

A Too quick. Yes.

Q Could you explain why?

MS. HERNANDEZ: Objection.

You can answer.

A Okay. We have developed more robust services. We've been able to create new service models and emphasize that the institution is not the first pathway for care. Really prevention and early intervention are better forms of treatment in healthcare.

Q Have the new or more robust services developed as a result of the sentiment been

effective in keeping adults out of institutions, in your opinion?

A In my opinion, yes.

Q Also, under your Deputy Chief of Staff position, the resume identifies you as having responsibilities for "Medicaid financing, compliance, and quality oversight for approximately $175 million of Medicaid behavioral health administration and services."

Do you see that text?

A Yes, I do.

Q Could you describe what you meant by compliance and quality oversight for 175 million of Medicaid behavioral health administration and services?

A So in that role, at that time, the work that was ongoing through a vendor -- it was not the ASO model at the time. It was what was -- it's precursor.

The administration of that and the oversight of that was under my authority. So the localized quality audits at the time of providers that looked at their compliance with the policy and the quality at that point in time was under my leadership.

Q When you say "the policy," are you referring to DBHDD's program manual?

A Yes, the program manual. Yes.

Q So you were assessing provider compliance with the DBHDD program manual?

A Through the external review organization, yes.

Q And when did ASO come online?

A Approximately 2015, best to my recollection. It was a process to pull them live, but it was in the mid-teens.

Q And when did the State of Georgia shift to a managed care model?

A 2006.

Q Did you have any involvement in that transition?

A Yes.

Q Could you describe what that involvement was?

A Yes. Prior to 2006, the behavioral health benefit package under the Medicaid State Plan was fully administered by our department. At the time of this transition, then that targeted population then was segmented and moved to the Care Management Organizations.

So for about a year and a half we were engaged with the Medicaid authority to understand what their procurement would look like. We were reviewers of the procurements, of the proposals, but not scoring reviewers. We just read them cold and just answered questions to the Medicaid agency about that process, and then once the work went live, then we actually at that point in time pulled back from any work related to those covered lives.

(Discussion ensued off the record.)

BY MR. HOLKINS:

Q Okay. So just to confirm for the record, it's now the Georgia ASO Collaborative that's responsible for this function of overseeing the reviewing provider compliance with DBHDD's program manual?

A Through our oversight and contract.

Since we had a little break there, I just want to go back and confirm, the ASO does those reviews only for DBHDD covered lives, not for managed care covered lives.

So because, because you left on that question, there was a pause and came back, I just want to be sure that that's clear.

Q So who is responsible for reviewing

provider compliance for the Medicaid covered lives -- is that correct? Covered lines?

A Lives.

Q Lives?

A Lives. So Medicaid covered lives through DBHDD are only used, in this case that we're talking about today, youth who would be determined aged, blind and disabled. So it's a very small number of youth.

The remainder of youth are covered by the managed care companies.

So what I was clarifying is that the ASO does not review any of the quality compliance or oversight for the managed care covered lives.

Q I want to give a concrete example, just to make sure we understand what you're saying. I think it's clear but I want to be certain.

If a child is enrolled in Medicaid but does not fit into the narrow subset of population that is directly served by DBHDD and receives a Medicaid reimbursable service like IC3, the Georgia collaborative ASO wouldn't be reviewing quality compliance with respect to that service?

A Correct.

Q Who would?

A With respect to that youth?
Q With respect to that youth, yes.
A With respect to that youth, correct.
Q Do you know who is responsible for reviewing that service for that youth?
A I do not. I have a sense -- Let me just say -- like I want to be completely honest.
I have a sense that the CMOs have responsibility for that, and then there's quality folks embedded in DCH, but I do not know with great visibility or great accountability to this process how to define that.
Q Right. So it's fair to say -- as --
MR. HOLKINS: Let me rephrase.
BY MR. HOLKINS:
Q Would it be your best guess that the quality oversight responsibility for the services that we were describing for the youth that I offered in the hypothetical would rest with the CMOs per contract with DCH?
A That is my understanding, that that is the first line of quality.
Q Okay. So thank you for bearing with me. We do have a little bit more to discuss from your resume.

I want to go to the position described on Pages 1 and 2, Section Director, Provider Network Management, August 2006 to March 2009.

Do you see that text?

A I do.

Q Your resume references creating and operating the section responsible for providing network management with specific responsibilities for provider enrollment and expansion for behavioral health and developmental disability providers. Correct?

A Correct.

Q What did your work entail in performing this function, provider enrollment and expansion for behavioral health and developmental disability providers?

A Sure. So prior to about 2003, DBHDD only had about 30 provides with whom it worked, and beginning in 2006 or so we began to want to expand behavioral health capacity, and so in doing so needed an office in order to manage that, to kind of vet providers to be sure they met qualifications.

We began more Medicaid State Plan expansion, and so we needed to create, for instance -- this is a little old school -- databases for

being sure that we had providers in the system, that we had all their basic accreditation information, their fundamental credential information in the system, and then to begin to track how many providers we had for which type of services at the time, and to then be sure we also had the capacity within the ERO, the precursor to the ASO, External Review Organization, that we had the capacity then to get out and do those quality reviews.

So it was a developmental time for our department moving from being a very small operator to a much larger operator of services.

So it was creating the infrastructure in order to be able to grow from the early oo's to now, where we have many more providers.

Q And to be clear, the providers that you're bringing online are serving both youth that are direct DBDHH beneficiaries and other Medicaid eligible youth?

A Potentially. We don't govern that. So we approve the providers based on our policy, our credentialing expectations. The Care Management Organizations have the prerogative to recognize them or not, or even recognize them in the same way or not.

Q Okay.

A So we may have an agency. They may want to recognize practitioner level detail. So it's not always even comporting with the same provider network model.

Q Is it fair to say that approval by DBHDD as a provider doesn't guarantee that a provider will be recognized by a CMO?

A That is correct.

Q Is there ongoing work within DBHDD with respect to a behavioral health provider enrollment and expansion?

A Provider enrollment, yes. We don't necessarily have a plan for expansion. So at this point in time this was a huge growth moment from 30 to over 200 during this tenure, but we do have an infrastructure and operations now to continue provider enrollment but there's not a very specific expansion plan.

Q What is the -- who within DBHDD has direct responsibility for provider enrollment?

A It's under the direction of Camille Richins.

Q Could you spell her last name?

A R-I-C-H-I-N-S.

Q Thank you.

So also under this position, which is Section Director, Provider Network Management, from August 2006 to March 2009, you reference tracking access to community behavioral health service.

Do you see that text?

A Yes.

Q What did that work entail?

A So for us, for instance, it meant looking regionally, did we have certain types of providers in certain parts of the state, did we have coverage of all of the counties. So that type of access.

Q That would have been done at the service level?

A It would have been done -- what I would call like in groupings. So if you think about community outpatient services. It's not linearly each service. It's about our community outpatient services kind of as a group, accessible in that way.

So not by very specific granular line items but kind of global buckets of service.

Q And do you know whether there were assessments or were you directly involved in assessments of access to school-based behavioral health services?

A No. School-based behavioral health services were just part and parcel of being a general outpatient service.

So we had allowances for services to occur in homes, in schools, in churches, wherever we need to meet the person, but there was no tracking aspect or even kind of tagging of where the service would occur.

Q Do you know whether currently there are ongoing efforts to track school-based behavioral health services statewide in Georgia?

MS. HERNANDEZ: Object.

You can answer.

A There -- there are efforts. It's very difficult to tag a claim to determine where a service occurs. Where we have contracts for some school-based services, then we can ask those providers for that. So we have that as a group but other providers can still do school-based services without one of those contracts. We have that allowance, which we've had in place since, since I understood Medicaid at all, back in 1999.

There was an allowance to do school-based services. So providers can do that work at any point in time and it not be under a specific

contract with us, and therefore in the absence of any kind of tracking tag for that, we wouldn't have knowledge that that is occurring.

Q And when you say --

A We promote it. We just don't have knowledge where it always is occurring.

Q Okay. When you say "tracking tag," are you talking about something in the Medicaid claims data that would say this service was provided in a school?

A Yes. Yes. Place of service, which is a type of code, has not always included school. And early on with Medicaid we -- there's what's called a community mental health place of service code, and everyone who did community-based mental health was instructed to do use that as the place of service. So then historically there's not been an IT construct to tag where services were happening.

So that is evolving from the federal level at this point, more place of service codes, but historically that's not been a pathway for us to do that kind of tracking.

Q You also reference training and orientation to the behavioral health system, and this is under the bullet Developing and Managing an

External Review Organization.

Do you see that text?

A I do.

Q What work was being done at this time with respect to training and orienting to the behavioral health system?

A So, again, this is a narrow time frame that's identified here, but we were bringing on board very new providers to the system, right, again referencing that period of growth. So we were training them on like some generalist kind of Medicaid 101 constructs that have to do with like federal policy, like no self-referral. Like you can't just refer folks in-house. That was a Medicaid rule at the time.

So general, very global Medicaid rules. But then expectations about how to engage with the External Review Organization, how to fill out the forms of the External Review Organization.

And then we were doing some orientation to some emerging services at the time. So like intensive family intervention is a child-centered service, and we would roll out some training specific to some of the child centered services on an episodic basis.

So that's kind of the gist of the types of trainings we were doing at the time.

Q And, to your knowledge, are there ongoing efforts to provide training and orientation to the behavioral system to providers?

A Yes.

Q Within DBHDD?

A Yes.

Q Could you describe those efforts?

A I can't because I'm not, I'm not over those. So I just don't have intimate knowledge of that, but I'm aware that we continue to do some orientation work but that we also continue to do like evidence-based practice training, offer free CEUs to providers and the like.

Q Who leads those trainings within DBHDD?

A Dante's office leads some of the more evidence-based trainings. We have a contract with the Center of Excellence to lead some of those trainings.

We acquire other subject matter experts to lead those trainings. But then Camille Richins' office works with the ASO to do some basic provider orientation and onboarding for providers.

Q And do those trainings include trainings

related to Medicaid?

A The Medicaid agency has been participating in those historically. During the pandemic, we had a modified model, so I can't very specifically to their ongoing participation in that.

But during this time frame, the Medicaid agency was participating in some of our orientation.

Q Just in terms of the subject areas covered in the ongoing trainings, does that include Medicaid?

A It does. It does.

Q So we're almost done with this document.

I did see your list of presentations as well and I wanted to ask about one specific presentation from 2013, which I know is a little while ago.

If you'll see -- I can probably highlight this for you.

Sorry, wrong one.

Do you see the text I've highlighted?

A I do.

Q So this is a presentation which you gave in 2013, along with several others, titled, "At Home, In-School, with Better Care, at Lower Costs: How to Implement Innovative Fiscal, Administrative,

and Clinical Approaches for Youths with Complex Needs."

Do you see that text?

MS. COHEN: And you're referring to Exhibit 137, page GA0429528?

MR. HOLKINS: Yes.

A I'm just -- I'm referring to what I see on the screen. I'm not sure if it's that, but I see -- I see exactly what you're highlighting.

Q Okay.

A I just had to move the camera. It was blocking part of it. So yes, yes. I remember this, this presentation.

Q What was the presentation about? If you could expand?

A Right. So we were largely talking about high-fidelity wraparound and parent and youth peer support as come national emerging practices to better support young people in the community early, ahead of institutionalization.

So, again, with that then it then bends -- in this case bends the cost curve.

So these partners, Sheila Pires, Diana Simons, and Eric Bruns, are national experts in high-fidelity wraparound. Michelle Zabel, who is

mentioned, she was in the State of Maryland, which was one of the partner states to us in the CHIPRA Reauthorization Act Grant, studying peer support and IC3, high-fidelity wraparound.

Q Is it fair to say that the general thesis of the presentation was that states, and Georgia specifically, can save money by meeting the needs of youth through IC3 and peer support as opposed to serving them in institutions?

A That was the -- that was the premise of the presentation.

Q Have you presented on this topic since then?

A Not specifically that I recall.

MS. COHEN: What is that noise?

THE WITNESS: Is that a ring tone?

MS. COHEN: Thank you.

A Not specific that I can recall. I've done many other child-centered presentations on service delivery, but I don't think one about bending the cost curve that I can recall, but if I scan through this document, I can tell you.

I present a lot.

Q So your resume also references consulting work that you've done with SAMHSA?

A Uh-huh. (Affirmative.)

Q Could you just describe at the 10,000 foot level the consulting work you've done with SAMHSA?

A Sure. With SAMHSA, it's very specific to adult peer support in general. So have been -- early in the 2000s Georgia implemented the peer support program. We were the first in the country. So SAMHSA and NASMHPD and CMS actually asked the State of Georgia to help other states on that process.

So largely adult centered.

Q So I'm just going to ask a few more questions about your duties and background, and then we'll take another break and we can order lunch.

Do you serve on any committees or work groups currently as part of your job duties?

A Yes.

Q Could you list them?

A I don't know. There are a few.

Okay. So the couple that I think are most germane I'll start with.

So there is the Interagency Directors Team for Children's Mental Health, and there is a collaborative implementation on infant and early childhood mental health with the Department of Early

Childhood Learning, where we are focused on considerations for policy and financing programs for infant and toddler mental health, advancing that body of work for the State.

I mentioned ACER, which is a, a collaboration between the Georgia Medicaid CMOs, the Georgia Medicaid agency, Child Welfare, and our agency to have shared information and coordination related to children and young persons behavioral health.

There are kind of ad hoc coordination committees that I serve on, on a -- you know, kind of on an episodic basis, depending on what the need is, but I'm thinking that that is the majority.

With IDT there's sub and subcommittees and working groups of that, with the infant early childhood mental health is the same.

I think those are the ones I'm most active in at the moment.

Q Are there any ad hoc coordination committees that specifically relate to children's behavioral health services that you serve on?

A The ACER group is, is child centered. The infant and early childhood, that is child centered.

Q I'm just trying to make sure there weren't

others beyond the ones that you specifically identified.

A Not that I can think of.

Again, with Interagency Directors Team, that work is so vast, there are subcommittees and working committees as a subpart of that that I spent a lot of time on.

But I think if you think about the umbrella, that kind of covers the bases for that.

Q We'll talk about some of those committees in more detail a bit later on.

I want to ask you about your coordination with entities outside of DBHDD. I'll just run through a list.

A Okay.

Q Let's start with the Georgia State University Center of Excellence, or COE.

A Uh-hum. (Affirmative.)

Q Do you coordinate with COE on a regular basis?

A Yes.

Q With whom specifically?

A Almost all of their staff off and on. Again, there are projects that ebb and flow. So in the IDT meetings, of course their whole team comes

and participates, so I'm interfacing there.

And then in subwork groups, it depends. So I mean I could just start naming a lot of names, but I don't know how helpful that is.

Q Let me just try to narrow the field a little bit. Do you coordinate with Dimple Desai?

A Yes.

Q Do you coordinate with Susan McLaren?

A Yes.

Q Do you coordinate with Ann DiGirolamo?

A Yes.

Q I hope I said that right.

A DiGirolamo.

Q I know you have coordination with the Center of Excellence through the monthly meetings that you described, I think ACER meetings; is that right?

A They attend, yes.

Q Do you have stand-alone meetings of your own separate from the committees with the Center of Excellence?

A Only project specific, not standing. So, for instance, we are working on renewing like a data use agreement that the COE has with the Department of Community Health, and so I will, you know, just

call a 30-minute meeting with the DOE -- excuse me -- the COE team and just ask them for updates on how that negotiation is going.

We're not a responsible party, but we are beneficiary of the data when it happens. Dante holds the contract with the COE. So for them to accomplish their work, that's a helpful product, and so then what that allows me to do is also, as a state agency, partner to DCH to say, hey, how is that data use agreement work coming.

So there's little tiny ad hocs, where I would pull off to the side to have some specific meetings, but it is rare that I would be in a meeting with them 101 -- one-on-one where I would call them regular meetings in any way.

Q Do you have any ongoing coordination with the Carter Center?

A Ad hoc.

Q About what?

A So generally about peer support. Sometimes about parity, and there have been -- when they were launching their school-based mental health policy work, just some incoming phone calls about, you know, how does this look? Like how does this look in Georgia? Because they were trying to learn

some of that content. But generally that was always done in coordination with Dante's office since he's the contract holder and bearer of that.

And so I haven't participated in any ongoing meetings or standing meetings with them on that at all.

Q Do you have ongoing coordination with the Georgia Ombudsperson For Children?

A No.

Q Are you familiar with Melissa D. Carter?

A Yes, but just very peripherally.

Q Never worked with her directly?

A Not really. Like we've like been in meetings together, or, you know, like when there's been like a children's collaborative is brought together, like I've seen her name. I know her name. She would say she knows mine.

We've seen each other on the screen, but not in any way that's been like the two of us concertedly working on anything ever.

Q Do you coordinate on an ongoing basis with Voices for Georgia's Children?

A Yes.

Q About what?

A Primarily in detail around a specific

project. So I serve as the co-chair of a subcommittee of IDT to focus on behavioral health services mapping, and my co-chair is Melissa Haberlen DeWolf with Georgia Voices, and so I talk with her on a regular basis about some of that coordination work.

And then episodically, again just very ad hoc, whatever is kind of bubbling out in mental health policy work where they need some interpretation of how does that work, which I would respond to almost any children's advocacy organization like that in the same way. Just, you know, how does this happen? How does this work? What is your lens on this? That type of thing.

Q Could you briefly describe the behavioral health services mapping that you referenced happening as part of the IDT effort?

A Sure. It is an initiative where we are trying to look at the finances and funding for children's work to map what agencies kind of hold those lines of work and lines of authority.

So the project's incomplete. It is a work in progress, but basically every public agency who is a partner in IDT, who has some investment in children's behavioral health in some form or fashion

has been surveyed about the types of programs that they might target for children's behavioral health and where it was possible about how much money was targeted to each of those kinds of lines of business in order to document that.

Q What is the deliverable that you all are working toward?

A A map. Basically just an overview of all the ways that behavioral health is paid for and supported for children in Georgia.

So that is the hope. It has been a bit of a rocky road because behavioral health services and supports are so vast and they're so diverse, and many of them are nonquantifiable.

Like if we do suicide prevention, that's a marketing campaign. So it's very difficult to quantify that. So it is a long work in progress.

Q Would you face the same challenges in trying to quantify Tier II and Tier III services?

A Because those services are generally what is called in healthcare a traditional fee-for-service model, where a unit is delivered and it's paid and it's put into an IT system, that is the easier part of the work.

So that is not problematic for, for us at

DBHDD, and for the other agency -- the only other agencies who pay for that is the Medicaid agency.

So it just will really -- it's about translation for the CMOs because they organize sometimes their content differently that things get a little more gray, but we are in the process of trying to discern all of that detail.

Q Just to be clear, has your subcommittee completed work on mapping the Tier I and Tier III services?

A Not completed.

Q Any obstacle to that is the CMOs?

A No. The obstacle is really the amalgamation right now of that information. We did have some delay on the CMO data, but that has been resolved. So at this point it's really about looking across all those agencies and bringing that information together.

Q Is IDT also looking at access to specific services for every region of the state?

A I guess, for the record, there was a wreck outside.

So for -- I cannot recall specifically if there is a committee for -- that's targeting access specifically, but it is a common theme of

conversation for the IDT.

Q Do you have regular coordination in your official responsibilities at DBHDD with the Georgia Advocacy Office?

A No.

Q Are you directly responsible for providing any training or technical assistance to DBHDD staff?

A No.

Q Are you directly responsible for providing any trainings or technical assistance to community service providers in Georgia?

A Episodically. Not on a regular basis.

Q And when you do these episodic presentations for providers, what are they about?

A Generally, they're about a unique service. For instance, if we're implementing a new service for a Medicaid roll-out, I would present on that.

So, you know, like I indicated that 988 is a new body of work. I'm on the team for the department rolling that out. The providers are seeing an awful lot of me on that. That's not a Medicaid program. It's Medicaid supported but not necessarily what you would call a Medicaid program. But the providers are seeing me a lot right now on that topic.

Q I bet.

Your presentation specifically about implementation of 988, are those open to all providers in the State who are participating?

A Yes, yes. If there are -- if it's a targeted service, then it's a targeted distribution list, of course, but generally most of these trainings that I would do are pretty open access.

Q Have you led presentations directed at providers with respect to IC3?

A Yes.

Q With respect to the autism outpatient benefit we discussed earlier?

A Only at its initial opening, because, again, like my only participation was in the first year and a half to two years as being kind of the chair, facilitator, bringing that together.

So I would have been in presentations about the whole of the benefit but I was not the voice of articulating the ASD outpatient benefit. In that case I was co-presenting.

For instance, Marcey Alter would have been the collaborative partner at DCH who would have been the voice of that, although I would have been in the panel and having facilitated the training actually

occurring.

Q Are you directly responsible for providing trainings or technical assistance to the Care Management Organizations?

A There's no official responsibility of mine for that.

Q Have you unofficially presented to them?

A ACER serves as the space where we collaborate, and so, yes, in that space I have provided information. I wouldn't necessarily call training; it's just more -- because the whole purpose of that group is about collaboration. Myself and then many other partners at DBHDD, we try to bring information in, and the CMOs also bring information to the table in that same way.

So I think it depends on the -- how formalized you're couching presentation, whether or not that's kind of upper case or just less formally.

Q So I'm just going to quickly pivot back to your bio, which was attachment -- the first attachment to Exhibit 137.

In the middle of this paragraph, you reference that the majority of your career has been spent as liaison to the State Medicaid Authority.

Do you see that text?

A Uh-huh. (Affirmative.)

Yes.

Q Prior to joining -- thank you.

Prior to your taking on this role, was there anyone serving as liaison to the State Medicaid agency?

A No.

MR. HOLKINS: I think now is a good time for us to take a break.

What I would propose is we break for as long as we need to to order lunch, use the restroom, and then go back on the record for maybe another 45 minutes until lunch arrives, and then we can take lunch.

Is that okay?

MS. HERNANDEZ: That works.

MR. HOLKINS: Thank you.

THE VIDEOGRAPHER: Off record at 11:29.

(A recess was taken.)

THE VIDEOGRAPHER: Back on the record at 11:47.

BY MR. HOLKINS:

Q So the first thing that we're going to do, Ms. Tiegreen, is to introduce a new document.

We can put aside virtually the resume and

bio. I'm going to show you a document that was previously admitted.

(WHEREUPON, Plaintiff's Exhibit-8 previously marked for identification.)

BY MR. HOLKINS:

Q Okay. So you should now see what was marked previously as Plaintiff's Exhibit 8, and I will represent for the record that this was a letter that the United States received from counsel from the State of Georgia on February 12, 2021. It contains on Pages 2 and 3 supplemental information in response to the United States Interrogatory No. 17, and specifically the State identifies Medicaid available community health behavioral health services available to children in schools in Georgia.

Ms. Tiegreen, you mentioned that you have had some involvement in preparing responses to the United States discovery requests.

Did you have any involvement in preparing the State's response to Interrogatory No. 17?

A Yes, I did.

Q Did you pull together this list of services?

A Yes, I did.

Q And just so you know, when I refer to or ask questions about community behavioral health services for children in Georgia, will you understand that I'm referencing this list of services?

A Yes.

Q We've talked a bit about already -- we can put this aside for now. You need to see it? Would you like to --

A No. I was just moving the camera in case I needed to. So I'm good.

Q Okay. We talked a little bit about the various ways the State pays for behavioral health services for children. It would be helpful if you could just give kind of a list, a comprehensive list, of the ways in which the State is financing behavioral health services for children.

A I'll give it a shot. That's pretty big.

So I will -- where to begin.

Let me just begin with DBHDD. DBHDD pays for Medicaid services for Medicaid beneficiaries who have been adjudicated through a disability process. the federal term would be aged, blind, disabled.

So there are certain Medicaid beneficiaries who have been through an adjudication

process where they have been determined to have a disability, and those individuals DBHDD collaboratively provides a service benefit for with the Department of Community Health.

So the list that was just previously shown in that document, for those beneficiaries we and the Department of Community Health together implement those benefits for those youth.

DBHDD likewise, to create policy synchronicity, cover those exact same benefits for uninsured youth. There should be very few of those in Georgia but there are, and we provide the exact same service list, so that those youth have the exact same access to those services. Those are reimbursed through funds that are appropriated to DBHDD that are pure state funds.

So that same list access exists for those folks.

Additionally, there are some services which are not, intuitively or via policy, allowed or either easy to be allowed through a Medicaid benefit that DBHDD provides via state money.

For both of those beneficiary types -- so they may be Medicaid but we may provide services. So we have a service called Mobile Crisis, and in a

crisis situation it's often difficult to verify insurance coverage in that moment. The crisis is so acute.

So we have made a collaborative decision with the Medicaid agency, but that's not a Medicaid service. It's available to Medicaid beneficiaries but it is not what we would call Medicaid State Plan service.

So we have an additional set of services in that vein, which are also available through state appropriations or either through what is called the federal block grants through SAMHSA, who you referenced earlier, where we have block grants to do certain types of services and provide those for beneficiaries.

So that's a radical oversimplification of what DBHDD does in terms of financing.

Q Okay. Let's just actually stop there and I'll ask you a couple of questions and then we can cover agencies outside of DBHDD.

For the state appropriations funded service, like Mobile Crisis, which you just described, when those are funded in that way and not through a block grant, is it done fee for service?

A No. It's done through a contract, a

capacity contract.

It would depend on the service. So that answer is very specific to Mobile Crisis. We have some contracts that are capacity. So for Mobile Crisis, for instance, we say you're available 24/7, your practitioners are sitting waiting. It is not a fee-for-service model. It's about a performance expectation. So when a crisis call comes, you deploy and you are there within 59 minutes, right. That's more of a performance and capacity contract.

Other services could be paid for based on a unit of service provided. Where we can quantify that, then we do so in our, our encounter base system through the Administrative Services Organization where we can say, oh, a unit of this was provided, please submit a billable unit, tell us to whom it is attached, right, the person served, and then we can count that.

So a lot of it depends on the type of service, how we count and gather that information, or even if we can account and gather for that information.

Q What services specifically is DBHDD relying on the block grant from SAMHSA to fund right now?

A I can give you a handful that I am aware of, but I will not be able to give you the comprehensive list because I'm not overseeing any of that block grant.

But, for instance, we are right now leveraging some funds for our Georgia Crisis and Access Line through the block grant to be sure we have enough call consultants answering the phones for the Georgia Crisis and Access Line, in the up-ramp to the 988 implementation. So that's one example.

We are using some of the block grant funds for some of adult peer support services and through ARPA and some of the block grant monies that are coming like as part of rescue funds. There's a lot of pilot initiatives we're rolling out, for instance. But the list is deep. So I just won't be able to speak to them --

Q Understand.

A -- comprehensively here.

Q Sorry. And thank you.

Do you know whether the State is using the block grant through SAMHSA to fund any school-based behavioral health services for children?

A I do not know that.

Q Do you know whether the State is using any ARPA or rescue fund money to support school-based behavioral health services for children?

A I don't know that either.

Q Who within DBHDD has direct responsibility for the block grant from SAMHSA?

A So Jill Mays is the federal block grant director, the administrator for our departments, and then of course very much like my role, she is shaped and influenced in the creation of that plan, for that federal grant, through the service line administrator.

So, for instance, Dante creates the list of content that he would want developed for the Office of Children and Young Adults and Families, and he works with Jill on creating that body of work.

Q And who within DBHDD -- let me ask it this way: Is Jill Mays also responsible for administering or making recommendations with respect to use of the ARPA funds by DBHDD?

A She --

MS. HERNANDEZ: Objection.

You can answer.

A She coordinated the ARPA response for the

SAMHSA ARPA funds.

Q As distinguished from non-SAMHSA?

A Yeah. There were other ARPA funds that came into the state that are vast but not -- they weren't running through SAMHSA into our department.

Q So going back to my original question about the ways that the State pays for community behavioral health services, we talked a bit about DCH and the CMOs and their role in funding Medicaid reimbursable services for non-DBHDD beneficiaries?

A Uh-hum. (Affirmative.)

Q I think we could probably set that aside for now.

Do you have any understanding of the role played by local education agencies, or LEAs, in financing services --

MS. HERNANDEZ: Objection.

Q -- for children with behavioral health conditions?

MS. HERNANDEZ: Objection.

You can answer.

A I'm aware of what LEAs are. I am aware of their role, but I am not involved in any kind of administration or committees or understandings. So I can't really speak to how vast or deep their role

is and I can't speak directly to any of that policy either. So I'm just aware of what they are and how they function, but that's the extent of my knowledge.

Q Can you describe what they are and how they function?

A They are -- hardly. Let me just say that.

Q I was just taking your word for it.

A Hardly.

So I mean that they are local education agencies who have made some -- who have hit some threshold of qualification to provide some services directly themselves through the Medicaid agency, but we did just a brief learning about them in the autism initiative in terms of how any of that policy might need to be impacted or not, and with that it was almost like a touch-and-go in terms of my understanding of what their role would be.

And so I don't directly really understand how robust the benefit is or how it's described or defined. So I can't speak anymore to that.

Q Let me just ask this: Can LEAs enroll as a Medicaid provider?

A I'm reluctant to say so. I think the Medicaid agency should answer that question because

I don't feel assured about an answer.

Q Have you ever been aware of an LEA enrolling as a Medicaid provider?

A It makes sense to me because there's an LEA manual, and someone has to provide that, but I can't answer for that specifically. That's just not a body of policy I've gotten into.

Q What is the role of school districts in financing community behavioral health services for children?

MS. HERNANDEZ: Objection.

You can answer.

A I'm aware that schools can invest in doing some behavioral health provision of services locally, but I have no in-depth knowledge of how that plays out to Georgia or to the extent it plays out in Georgia.

I am aware through dialogue and IDT that that can occur, does occur, but I don't have any breadth or depth of knowledge of that.

Q Would you expect that the Georgia Department of Education to know about whether schools are enrolling as Medicaid providers?

MS. HERNANDEZ: Objection.

You can answer.

A I would just hate to conjecture. Again, I haven't worked with them in that level of weeds at all on how they implement service.

Q You mentioned this is a topic that has come up in IDT meetings?

A Uh-hum. Uh-hum. (Affirmative.)

Q Who has raised the issue of schools directly financing school-based behavioral health services in IDT meetings?

A Dr. McGiboney, who was with the Department of Education for many years, would often make reference to that, and then Ashley Harris briefly was a liaison in IDT from the Department of Education and would make reference to that, but is not the subject of any extensive dialogue or conversation that I've ever participated in within the IDT.

Q Do you have any awareness of the State's financing of school-based behavioral health services through the GNETS program?

A No, I do not.

Q So I'm going to stop sharing Exhibit 8 and show you a new document.

Give me one second and I'll pull it up.

A If I can just clarify my last statement.

When you said through the GNETS program, I said I do not. If those youth have Medicaid coverage, they would have access to a benefit plan, and so I am aware they would have access to plan services. But I'm not aware of any direct services through GNETS.

Q Understood.

A I have no knowledge or information about anybody they have there or content or aspects of that program. But I felt like I probably should clarify that based on your phrasing of the question.

Q Okay. I just want to make sure that I understand.

So you would have awareness about access to the general menu of Medicaid services --

A Exactly.

Q -- by GNETS enrolled students?

A Exactly.

Q Okay. But not specifically services they are accessing through GNETS?

A Correct.

Q I have just published the next exhibit, which is 138.

This is an email with an attachment. I'm going to put them together as one exhibit.

(WHEREUPON, Plaintiff's Exhibit-138 was marked for identification.)

BY MR. HOLKINS:

Q The email is marked GA 04199954 and this appears to be an email from you, dated 8/25/2016, to Marcey Altar with the subject: "CMO Work."

Is that accurate?

A Uh-hum. Yes.

Q You reference in the body of the email a presentation, which I believe is attached, "2015 RFP DCH CMO Briefing."

Is that accurate?

A Yes.

Q I'd like to show you that attachment. Give me one second and I'll pull it up.

A Okay. Thank you.

Q So this is the attachment for the email we just reviewed, and for the record the Bates-stamp is GA04199955.001.

If you would like, please take a moment to familiarize yourself with this PowerPoint. I'm going to give you control.

MS. COHEN: That exhibit number will be Exhibit 39 that has the GA0419954 and 55?

MR. HOLKINS: This is 138.

MS. COHEN: 138. Excuse me.

MR. HOLKINS: Yeah.

(Witness reviews exhibit.)

A Okay. Yep, I'm familiar with it.

Q So I'm going to take control back and scroll up to the top of the document, which as Fran mentioned is part of Exhibit 138.

Ms. Tiegreen, can you explain what this presentation was about?

A Certainly. So the DCH extended an invitation to DBHDD, as well as to the Department of Juvenile Justice and the Department of Child Welfare, DFCS, Georgia, as well as the Department of Public Health, to be Subject Matter Expert reviewers of the proposals to award the potential CMOs for Georgia.

And in doing so -- as a result of doing the Subject Matter Expert consultation, this is a summary of the comments as I saw them in my role for DBHDD, in order to share and present with the DCH team summation and to inform our internal leadership post the award, because I couldn't do it before the award, post the award of my reflections on the take-aways, the large trend take-aways from that procurement review process.

Q So why couldn't you provide this feedback internally to DBHDD leadership until after the award?

A So just in keeping with the, the standard of kind of procurement expectations put forth on reviewers, that whole process is protected and until contracts were fully negotiated.

Q So this is a summary of review work that you assembled from the summer of 2015, correct?

A Uh-hum. (Affirmative.)

Q Have you had occasion to put together a summary like this since then?

A No. No, because this was very specific to the proposal review process. So there's not been a proposal review process since then.

Q Have there been contract renewals with the Care Management Organizations since the summer of 2015?

A I hear from DCH peripherally that there are, but we have not been asked to inform that process.

Q I just want to make sure I understand.

Who were the Subject Matter Expert providing the comments? Were those individual staff within DBHDD, for example?

A There was one rep from each of those agencies that I named who were identified to be subject matter reviewers.

Q And were you that person for DBHDD?

A I was that person.

Q Oh, thank you.

So I'm going to skip down some pages to ask you about some of the overarching trends, which is a section that starts on Page 4.

A Sure.

Q At the bottom of Page 5 there was a recommendation that DBHDD assist in connecting the CMOs elect with the Center of Excellence for resource leveraging.

Do you see that?

A Yes.

Q Do you know whether in fact DBHDD did connect the CMOs with the Center of Excellence as a result?

A Yes. They were all invited to be long-standing, permanent members of the Interagency Directors Team, and they all participate on a regular basis.

Q On Page 7, at the top of the page, there is a recommendation with respect to EPSDT.

Do you see that?

A I do.

Q The recommendation reads: "DCH clarification with the CMOs-elect on the full scope of EPSDT to include processes and protocols for off-plan services when identified as medically necessary."

Do you see that text?

A I do.

Q And above it: The observation, I think that you summarized from the review, is that "EPSDT seems to be generally discussed as a list of required 'exams' or 'test' or 'interventions.' It appears the respondents are considering it as wellcheck content only."

Do you see that?

A I do.

Q What did you mean when you said -- or when you wrote that "respondents are considering it as wellcheck content only"?

A So I'm harkening back, this is aways, but there are general -- the EPS part of EPSDT named some general screening that should happen for young people at certain developmental stages, and the tenor of some of these responses was largely

affiliated or seemed to spend a lot of time on that EPS part of EPSDT.

So that's when I'm thinking about like well-check and exams and tests, that there are identified benchmarks that are part of the early childhood screening processes for healthcare conditions that typically occur.

So that is what that references.

Q Okay. Is it fair to say the concern was that based on the proposals you were seeing from the CMOs elect that they were focused on the early and periodic screens but not on the medically necessary services and interventions that may be required?

MS. HERNANDEZ: Objection.

You can answer.

A That is -- was kind of the basic sense from those responses, which is why we called this to the attention of DCH.

Q And what was the result of the recommendation with respect to this particular issue?

A I do not know because this would have been a DCH to CMO clarification and not anything our department was responsible for recommending.

Q Skipping down to -- first off, would Brian

Dowd, to the best of your knowledge, have responsibility for implementing this recommendation with respect to EPSDT?

A At the time, Marcy Altar had this role and functionality, so I can only speak to at the time. It wasn't Brian who I was working directly with on this type of content. It was Marcy Altar.

Q I think you testified previously that Brian Dowd has stepped into a similar role as Marcey; is that correct?

A A similar role. Again, post-Marcey, the work was redefined and kind of spread. And so it is not, I don't think, a direct one-to-one, but we continue to work with Brian on many aspects of the Medicaid program.

Q On Page 8, your presentation identifies "a significant lack of attention across all proposals to individuals with Intellectual and Developmental Disabilities (IDD (with a couple of small exceptions in Care Coordination sections)."

The recommendations you make are, one, "DCH can request additional supporting information to assure that IDD issues will be coordinated and addressed." And "DBHDD can provide technical assistance to the DCH."

Do you see that text?

A I do.

Q I note that in the left -- to the left of the text there's a red stop sign?

A Uh-hum. (Affirmative.)

Q What does that signify?

A So for purposes of this presentation what I was signaling to the Medicaid agency is my personal lens as the Subject Matter Expert on the criticality at which they should be addressing some of these issues, and so in this case signaling that I found this, from our Department's lens, of course, with our mission and purpose, this to be a critical aspect that they should begin to address with the vendors.

Q Are you aware of what the result was of the recommendation you made here?

A I am aware of what I specifically did related to this, and we did a very high-level orientation to the CMOs on some role and functionality, very specifically related to care coordination, because of the service that's embedded within the intellectual developmental disabilities waivers in Georgia, where care coordination happens under a service construct called support

coordination.

So we did do a training orientation, like a kick-off, to all four CMOs, where that was shared with their leadership.

Q Anything beyond that?

A No.

Q And do you have any knowledge of whether DCH in fact requested additional supporting information to assure that IDD issues would be coordinated and addressed?

MS. HERNANDEZ: Objection.

You can answer.

A I am aware of the process that DCH used to gather more information. So there were a series of what DCH called readiness reviews, where they had to -- where the CMOs were asked to submit policy, and then the Medicaid authority was asked to approve and vet that policy before implementation as part of readiness review. And so I do know that care coordination policy was part of that review but I cannot speak to the rigor, the outcome, the back-and-forth dialogue between they and any of the awardees in terms of how much work was done on that specific issue.

Q You testified much earlier today that part

of your job includes looking at youths of specific service within DBHDD's service menu, correct?

A Uh-hum. (Affirmative.)

Q Are you -- is that yes?

A Yes.

Q Do you specifically look at utilization of services for children who have IDD?

A Not specifically. So generally what we look at is some global trends for the services list that was named earlier, and so I look at those services trends but those are behavioral health services. So not specific to IDD.

Q So just to confirm, are you tracking utilization of the autism outpatient benefit?

A No.

Q Is there anyone, to your knowledge, at DBHDD who is doing that?

A Not at DBHDD. Those services are administered and managed by DCH. So we do not have any purview or lens into that program.

Q Is that even the case for youth who are direct DBHDD beneficiaries?

A So that autism benefit is a separate benefit program, and DBHDD does not administer a companion benefit for that. That was purely a

Medicaid initiative, Medicaid services, and other than the roll-out period, the developmental period, DBHDD has not been in an advisory role or a review role or an oversight role or monitoring role of that body of work.

Q I want to draw your attention to the next entry on the same page, which is Page 8. It reads: "Vendors seem to be lacking knowledge of the gamut of current community-based services and the breadth and depth of those services." In parenthesis, "in almost all proposals, physician assessment and individual counseling are the only named interventions, and while peer support is named, it is referenced as a service provided by the vendor, not a service provided by the provider network."

Do you see that text?

A I do.

Q You recommend that "once vendors are engaged, provide training on the scope of rehabilitative and recovery-oriented supports."

Was your expectation that DBHDD would provide that training?

A I hoped for that, and we did do some overview work on that but the recommendation is to DCH in this case because they would be the one

holding the contract with the CMOs.

Q So what's the difference between what you had hoped for and what happened?

A So we did roll out the global overview of services. And, again, I will reference back to my comment earlier about relationship. It depends on so much, right. Time, capacity, resources.

And in an ideal world we would be all defining every service aspect the same way. In reality, federal Medicaid gives managed care companies a lot of leverage and leeway through federal guidance to implement services in accordance with a state plan, but as they believe to be kind of the benefit designed for that specific subvendor.

So one of the Care Management Organizations can define services more uniquely under the framework of the state plan. So, so of course we have an interest in defining recovery as broadly as possible, and some of the CMOs will then say this is our understanding of the best practice for releasing this, and then sometimes those things are variable.

Q So, again, I'm just trying to understand what your expectation was and what in fact occurred. You mentioned the definition of recovery oriented

services, wanting that to be as broad as possible?

A Right.

Q Have you seen a narrower definition of recovery oriented services than you had expected?

MS. HERNANDEZ: Objection.

You can answer.

A I find that the way DBHDD often defines services in our Behavioral Health Provider Manual, that it is often more narrowly defined by the CMOs, and in other cases, to be fair, there are some places where they may define a bit more broadly, more often not in the realm of medical necessity, but more in like who is the provider network. And it's service dependent, and so there's a lot of variation in that related to specific services.

Q Do you have concerns right now about the knowledge of CMOs relating to community-based service and the breadth and depth of those services?

MS. HERNANDEZ: Objection.

You can answer.

A I find it to be a continuous dialogue, and I, I -- so this is all subjective. And I have no data upon which to base this, so I want to contextually offer that before I then say, there are often scenarios where we will hear that a youth

needed a service and couldn't get it, and I will often answer the question why.

And it's in the state plan. Or they couldn't get it from a certain practitioner, and I will say why, and it will be related to how they define practitioners who can do the service.

So that is the very narrow lens through which I get a chance to see this, because we don't see data, we don't see the global snapshot, and we don't see any broad evaluation content for the CMOs. So I just have a very limited lens through which to answer that question.

Q Is there anyone at DBHDD -- recognizing that you are the official liaison to the State's Medicaid agency, who would be in a better position to have line insight on CMO awareness of community-based behavioral services?

A No. Dante is my -- probably my greatest partner in that because so many children are covered. While there are adults covered by the CMOs, there are so many children covered. He would probably be -- have an equal lens on that, and -- but I don't think anybody else knows it better than he or I do.

Q If you were to call, pick up the phone and

call someone at DCH to ask a question about CMO awareness of community-based services, who would call?

A Brian Dowd right now. A month ago that would have been Catherine Ivy, prior to her departure, but right now it would be Brian Dowd.

Q Could you -- just a brief detour -- describe what Catherine Ivy's scope of work was, as you understand it, before she retired?

MS. HERNANDEZ: Objection.

You can answer.

A My perspective was that she was over all of the programmatic and service delivery aspects of the Medicaid services benefit. So not just for behavioral health but globally.

And, um -- so that would include almost most -- almost all of the clinical practice that would be set forth in the Medicaid benefit.

At the time she was doing kind of the practice aspects, and then Brian was doing more regulatory aspects of this, but in her absence and those positions not being filled in this moment, Brian is our point. But I hope that globally captures Catherine's role.

Q I'd like to set this document aside and

show you another one.

I think after this document, we can take our lunch break.

Actually, I'm sorry, I deceived you. I want to go back and ask you one more question about the email that you sent attaching the presentation we just described. This again is Exhibit 138. Give me a second.

So you recall this is the email that I showed you previously?

A Uh-hum. (Affirmative.)

Q It is marked as Exhibit 138.

Why did you think it was timely to re-send this presentation?

A So I cannot pinpoint the implementation deadlines without looking back at other documents. So I'm just going to state my recollection of the historical framework.

Summer 2015 we reviewed the procurements, and then there were months that went by before then the awards were announced, at which point then I was able to share the information in the slide presentation. So that was January. So while I don't specifically recollect the link from the GNETS suit, I imagine that it was saying to the Medicaid

agency, I hope you've had a chance to implement and have all the dialogues related to this that are necessary for good practice to occur from the CMOs, but I cannot pinpoint when the CMOs went live without looking at -- back at a record of when that actually happened, since we were not the contract managers for that. And even so, several of them, at least in the 2006 implementation, went live in stages. That's all I can say to that.

Q Just to put a finer point on this, for my own understanding, did you think at the time you sent this email that implementing the recommendations in your presentation would help the State address the allegations that the United States complained in its litigation?

MS. HERNANDEZ: Objection.

You can answer.

A The first thing, I just want to be clear about is whatever came across back then in 2016, I, I can't fully remember what was in that suit versus what is in the dialogue we're talking about for sure, but whatever it was, I knew it was child specific and I knew the CMOs had the largest and greatest purview and opportunity to impact children's administration because of the number of

their covered lives.

So in any kind of inquiry into the State's performance on children, I would have been like as a partner, have you, have you dotted all these I's and crossed all these T's.

Q Got it.

The GNETS suit that you reference in this email is this litigation, correct, to the best of your understanding?

A I think. I am not -- I am not positive but I think that would be the only one from that time frame.

Q All right.

Okay, so let's put this aside. I am going to show you another exhibit, which will be 139.

(WHEREUPON, Plaintiff's Exhibit-139 was marked for identification.)

BY MR. HOLKINS:

Q Do you see the email that I just published?

MR. HOLKINS: For the record, this is GA 04179924.

A It's up now, yes. Let me see.

Do I have control?

Q I will give it to you. Give me one

second.

The wrong button. Okay.

MS. COHEN: Patrick, what was the number?

Q You now have control?

MR. HOLKINS: This is Exhibit 139.

MS. COHEN: And the Bates number is?

MR. HOLKINS: I've already given it.

MS. COHEN: Okay. I know. I didn't hear it.

A Okay, yes.

Q So I will take control back of this document.

For the record, it is an email that you sent -- the top of this document I should say, is an email that you sent on September 23rd, 2015, with the subject "Re: Apex Billing Webinar." Correct?

A Yep.

Q And you attached to the email a document titled, "Apex Billing and Reimbursement," and there are in parentheses initials "MY" and "WT." Correct?

A Correct.

Q So were you providing comments in the document on this email?

A Yes.

Q I am now going to show you the attachment.

So this is also part of Exhibit 139. The Bates number is GA04179926.

Is this the attachment to the email we just looked at?

I can give you control.

A Thank you. I was wondering. Thank you.

Q You've got it.

A Thank you.

(Witness reviews exhibit.)

A To the best of my recollection, this is the -- what would have been a document that Matt Yancey and I would have responded to.

Q Thank you. I'm going to take control of the document back.

I want to direct your attention to some of the texts in this document.

A Uh-hum. (Affirmative.)

Q Specifically, on Page 2 of the document, do you see the bullet that reads: "Some services can be challenging to get authorized through CMOs"?

A Yes.

Q And underneath there is a sub-bullet that reads: "Wendy, every service in the Medicaid State Plan is required to be provided by the CMOs when medically necessary for the child."

A Yes.
Q Is this Wendy you?
A Yes. This is me.
Q Okay. And is it your understanding -- is it your understanding now that this is still the truth, every service in the Medicaid State Plan is required to be provided by the CMOs when medically necessary for the child?
A Yes, that is my understanding.
Q And that would include IC3?
A Yes.
Q Would that include the autism outpatient benefit we discussed earlier?
A While our agency does not administer it, it would still be the same premise, yes.
Q In fact, that includes all of the community-based behavioral health services --
A Yes.
Q -- that we described -- let me just finish the question.
So this statement would apply to all of the services that were identified in the State's supplemental response to the United States Interrogatory No. 17?
A Yes.

Q Do you agree with the statement that some services can be challenging to get authorized through the CMOs?

MS. HERNANDEZ: Objection.

You can answer.

A It is the self-report of provider agencies that they have had a challenge with authorization. So I can only represent what I hear through our provider agencies since I do not have any lens or data or direct information to that process.

Q So you're not, as part of your regular duties at DBHDD, looking at systemwide data relating to authorizations and denials for services by the CMOs?

A Not by the CMOs, no. Our agency does not do that.

We have had a quality improvement project or two with the Medicaid agency where we have been a party, or like a SME, a Subject Matter Expert, to a conversation on that, but in general we do not have any data information on that work, that policy, that protocol.

Q So under this bullet there's a statement that it's attributed to Matt. Which I believe is Matt Yancey?

A Uh-hum. (Affirmative.)

Q Is he still with DBHDD?

A He is not.

Q What was his role at the time?

A He was in the role of the director of Office of Children, Young Adults and Families. So he was Dante McKay's predecessor.

Q So Matt -- the statement attributed to him in this document, the bullet we were just discussing, again stresses the importance of sharing this in your monthly reports with your TA providers, et cetera, "so that we can take these problems to the State Medicaid authority and work on them."

A Uh-hum. (Affirmative.)

Q Do you -- you reference kind of provider self-reports. Is this what you were talking about through these monthly check-ins?

A Yes. This presentation was to the early recipients of Apex contracts from DBHDD. So we are responding to the COE in their role convening the providers who did the Apex contracts at this moment in time.

So what I recall and am reminded by this document is that Matt was indicating that the more data we could get from the providers on where these

challenges were at that point in time gave us then the type of information we needed to take to the DCH, so that they could inform and shape the performance of the CMOs.

Q And do you know whether in fact DBHDD is taking information about CMO denials to DCH?

A We --

MS. HERNANDEZ: Objection.

You can answer.

A We do so, again, episodically.

So as a result of this dialogue and conversation, we began conversation with the Department of Community Health, which then resulted actually in a CMO panel coming to present to these agencies, to talk with the agencies about the prior authorization protocols and the way they each operationalized it so that the providers were better able to respond to what the CMO desired, and so that the CMOs were able to get what they needed from the providers providing these services, hoping to build a better connective process so that the beneficiary was the winner in that, in that administrative smoothing.

So very specifically that was one outcome of this.

Subsequently, you know, there are -- have been moments where we've indicated some challenges back to the DCH and they take those to the CMOs and we're not -- that's not in our visibility, how it gets resolved. But that was one example of where there was a very collaborative manifestation of an improvement process.

Q Are you aware of any provider complaints about the CMO authorization process, specifically with respect to school-based behavioral health services?

MS. HERNANDEZ: Objection.

You can answer.

A Not in my recent times. So it has not been top of conversation in a bit.

For some time after this and before that paneling that we brought together with the CMOs, there were tremendous complaints, and then I think the more we kept presenting in IDT about the role of Apex and the goal of Apex, then I think the CMOs' practice just in those shared settings with us probably began to create better understanding related to access.

So there was not a concerted -- we had some concerted effort early, which you see as a

result of here. After that, it was more continuous education and information sharing about the goals of Apex towards the end of it being -- school-based services being more accessible.

And so we've not had a gathering of complaints, at least that's been in front of me, lately, unless Dante has had anything of that nature. But I've not been involved in anything related to authorizations related to Apex complaints in quite some time.

Q Okay. But just to clarify, you're not looking at data around authorizations and denials for school-based behavioral health services through Apex or otherwise billed to the CMOs?

A No. Because, again, that's not our purview. We just don't get a lot of information. If we get it, it's anecdotal. Our providers generally now know that we're not the catcher on those types of direct complaints, that that is a Medicaid authority dialogue.

Q Understood.

When was this panel, the presentation by the CMOs, done, do you remember?

A I do not, not without looking. It would have been subsequent to this because we had a lot of

concern and complaints that bubbled for a few months, and then we were able to get that panel presentation done, but I cannot recollect when that was precisely.

Q And just kind of pivoting back in the email, so it's clear for the record, you made these comments in September of 2015, correct?

A Uh-hum. (Affirmative.)

Q So the panel would have occurred presumably --

A After that, right.

Q So I would like to just --

A Because -- let me just say, it would have occurred after the CMO implementation. So just couching that from the last document, it would have probably at least been in 2016.

Q Okay. So I do want to show you just a couple of documents real quick before we take our break, because this is related to the same line of questioning. And then we'll take, I think, about 10 minutes.

MR. HOLKINS: So I've just published an email which is marked GA05023066. I'm introducing this document as Exhibit 140.

(WHEREUPON, Plaintiff's Exhibit-140 was

marked for identification.)

BY MR. HOLKINS:

Q I will give you control so you can familiarize yourself with it. Just one second.

You have control.

A Thank you.

(Witness reviews exhibit.)

A Okay. That is the panel that I was referencing.

Q I'm sorry, what are you looking at?

A The panel down at the bottom where Dante asks can we invite them to a panel with us. Second sentence. "CMO panel to talk through their representative philosophies and practices."

That was the panel I was referencing a moment ago where I wasn't sure of the date.

Q Okay. So this is -- let's kind of go back here.

This is an email chain in early 2018 between you and Dante McKay, correct?

A Uh-hum. (Affirmative.)

Correct.

Q You just referenced Dante suggesting this CMO panel you previously testified about?

A Uh-hum. (Affirmative.)

Q Is that yes?

A Yes.

Q And then above, in your response to Dante from January 3rd, 2018, you write: "That being said, it might expose to the DCH the CMOs' disconnect with our providers problematically so I am willing to endorse this."

Correct?

A Correct.

Q Could you expand on what you viewed as the time, as the disconnect between the CMOs and the provider problematic?

A Sure. So very specifically, there are service increments going back to the list that we provided in the interrogatories about how things are billed. So there are services in the Medicaid plan that are billed.

Then there are program models where you pull together a handful of those things to really make a program work. So very specifically, for instance, with Apex, Apex is a framework and in that framework children's behavioral health services can occur. They are promoted to occur. And those services could be individual counseling, they could be family counseling, they could be community

support. So those things are sub-increments of, of the Apex program model.

So Apex is a program. It pulls together some of those sub-elements of service, which then create school-based mental health programs. So a program, big umbrella, there would be sub-elements.

So when the CMOs were going live, it was becoming more apparent to myself, as reflected here in this email, that the CMOs were not clear on how some services should come together as a programmatic umbrella.

So when we would talk about Apex, for instance, or Substance Abuse Intensive Outpatient, which is mentioned here, SAIOP, those were programmatic models of service delivery where they had all of these sub-elements, but the CMOs just read the state plan and all they saw was the sub-elements. They didn't see the variety of ways that the State talked about services and programs coming together, braiding different strands of service together to make a program.

So when I'm talking about programmatically, sometimes our providers would -- this was per their self-report -- would call a CMO and they would say, we want authorization for Apex,

and the CMOs didn't understand that because for the CMOs it was like the child needs individual counseling, community support, physician assessment. It didn't matter if it was in the school or not, they were just thinking about the a la carte list and not the programs.

So that is really the crux of my statement in this context.

Q And what was the practical effect of that disconnect?

A If it -- the practical disconnect for me comes back to the last exhibit that authorizations were sometimes more fraught with dialogue or appeal or revisiting because there was not common language shared between the provider and the CMO, which was then our point for let's get folks together and learn about this as soon as we can, so that we are able to dispel any of these concerns related to access.

Q Okay. Thank you.

I've got one more document. We're almost done and ready for lunch. Give me one second.

Not done, just ready for lunch.

Actually, I'm going to hold that document but let me just ask, beyond the panel that you

referenced led by CMOs, was there any other effort to address -- by DBHDD to address this disconnect between providers and the CMOs?

A Yeah. I mean the creation of ACER did not happen until probably 2018 as well. I can't speak to the genesis date precisely, but the ACER group, the coordination that we embarked on with DCH and the CMOs was largely to really target -- the acronym, it's access engagement -- sorry.

Access Coordination Engagement and Recalibration, which was the terms that we collaboratively came up with with the CMOs to say, okay, we've got to be at a table talking with more regularity so that we do a better job talking the same language and implementing systematically some of these programmatic models that we really feel like are the best practices for Georgia's children and youth.

So that's really how we came to bring that group together, and it was -- the two departments and the CMOs together, recognizing the opportunity to be in a more shared collaboration, despite our agencies not having any authority over those contracts.

So, again, functioning as a Subject Matter

Expert, offering some interpretation of some programs, even sharing like where we had pilots beginning to emerge onto specific areas so that the CMOs were aware that some of this content was emerging, some of the ways we were looking at some opportunities for practice of the future, right, because none of this should be stagnant.

So that was really the largest and most permanent manifestation of some of those early frustrations and challenges, was to create that space, to have an hour and a half to two hours a month to just put a ton of stuff on an agenda and really better communicate.

So Medicaid agreed for us to assume the chairmanship role of that. And so DBHDD, my office, convenes that monthly.

Q Okay. Just to recap, the two remedial measures taken by DBHDD to address this disconnect between providers and CMOs was the CMO panel that you described and the formation of an ACER committee that meets monthly --

A Correct.

Q -- with the CMOs and DBHDD and DCH?

A Correct. I do want to be specific, though.

The panel was created specifically related to Apex.

Q Okay.

A But we also recognized, as you saw in the exhibit, that Substance Abuse Intensive Outpatient this was occurring for, and we initiated several trainings for the CMOs, like related to their understanding of IC3 because it was a new service that was again put in the state plan fall of 2017.

So there are iterative processes for that. So it's not like a one and done. So just as you just named a one and two, I just want to be clear, one was that panel, but it was very specific to Apex. Two is an ongoing process, but, again, periodically when we hear of these concerns, we at DBHDD, again not the authority, are trying to use the ACER now as the space to create that hardier dialogue, specific to whatever is merging as some place where we need to have better collaboration and communication.

MR. HOLKINS: Okay. Let's go ahead and break. I think we can take an hour, give everyone a bit of time. Come back at 2 o'clock.

Is that okay?

MS. HERNANDEZ: Yes.

THE VIDEOGRAPHER: Off record at 1:02.

(A recess was taken.)

THE VIDEOGRAPHER: Back on the record at 1:48.

BY MR. HOLKINS:

Q Welcome back, Ms. Tiegreen.

A Thank you.

Q I'd like to jump right into another exhibit. Give me a second and I will pull it up for you.

MR. HOLKINS: I've just published what I'm introducing as Exhibit 141. For the record, this is marked GA00381117.

(WHEREUPON, Plaintiff's Exhibit-141 was marked for identification.)

BY MR. HOLKINS:

Q It's an email from you, dated August 21, 2016, with the subject "Re: Medicaid Question."

A Correct. I can see that.

Q I'm going to give you control of the document so you can take a moment to take a look.

(Witness reviews exhibit.)

A This is just taking a moment because it's like a very unique question from one person, and so

it's taking me a second. I apologize.

Q Please take your time. There's no rush.

A Okay, I've just finished. Thank you.

Q Thank you. I'm going to take control back.

Let me first ask, who is Rebecca Blanton?

A Rebecca Blanton worked for the Department of Education as a grant manager for them specific to some behavioral health initiatives that they were implementing, and as such served as a member of the Interagency Directors Team, and at one point even for about two years held the chairmanship for that.

So she was a counterpart with the DOE who I worked within several committees off and on.

Q Is Rebecca Blanton still employed by the Georgia Department of Education?

A I believe she's retired.

Q And in this email, the most recent one in the chain, which is 8/21/2017, you're responding to an email from Rebecca Blanton, correct?

A I'm responding to -- it looks like a chain from the Center of Excellence at Georgia State University, fielding a question from someone who worked for Georgia State University, and then they kicked it over to Rebecca and myself, where she just

says: "Wendy would be the expert on this and I would love to know the answer, too."

And then of course I laughed because I'm not the expert on this, although I appreciated the vote of confidence.

Q So the "this" that you're referring to, unless I'm mistaken, is whether or not a child who is receiving Children's Intervention School Services would have their claims paid by CMOs?

Is that the question that's being posed?

A To me it is -- there's two aspects of this. It looks like it's asking some parameters of the Children's Intervention School Services, and then there's also content about LEAs.

So, again, like I've already articulated, I'm a studier of this information, but I have no policy authority, or do not touch this policy on a regular basis, which is why I also kicked this over to individuals at the Department of Community Health.

Q And specifically you referred this query to Brian Dowd and Sandra Middlebrooks at DCH, correct?

A Correct.

Q Still in your response you provide some

information based on your review of the CISS policy, correct?

A Uh-hum. (Affirmative.)

Correct.

Q And just to be clear, CISS, or Children's Intervention School Services, is one of the avenues you explained earlier for children to receive behavioral health services in schools, correct?

A Correct. And just to rearticulate, one of the avenues through the Department of Community Health, which DBHDD does not impact, interface or have any authority for, which is why I'm merely, in this case, copying and pasting some content from that policy, and then kicking it to the Medicaid authority.

Q You write in your email, dated 8/21/2017, based on the review of the CISS policy: "This leads me to believe" -- excuse me.

"This leads me to believe there may be different approaches in different geographic catchments."

A Uh-hum. (Affirmative.)

Q What did you mean by that?

A I don't have these policy citations in front of me, but I -- basically my understanding is

that schools can provide funds which are matched through the Department of Community Health, but they're not all jurisdictionally the same, but the Medicaid agency would have to reply to that because, again, this is -- I'm indicating here that I skimmed the policy in order to respond. I'm giving them the citations, but, again, I just am indicating back to these folks that I am no expert on this.

Q Do you recall --

A And I'll -- and I'll state that for this group, too.

Q Do you recall whether Brian Dowd or Sandra Middlebrooks responded to your email?

A I do not recall.

Q And --

A And they could have just replied to Dr. Snyder, and I would not have known.

Q And sitting here today, do you have any further understanding of whether CMOs can be billed for services through the CISS program?

A It is still my understanding that if it's in the Medicaid State Plan, that they are responsible for that coverage. That's the global understanding.

Q But that there may be some geographic

differences in terms of the matching funds provided by LEAs?

A Correct. Just, again, based on this read, and I can tell from my sense of response that those paragraphs gave me that indication, but, again, this was from quite a ways back and this is not my area of expertise.

Q Okay. So let's set this aside.

As part of your job duties, do you review or assess information relating to the availability of community behavioral health services for children in Georgia?

A In as much as we can, not being the authority for all services. So when I think about access and reviewing access on behalf of the Department, again, I think about things, am I seeing utilization in all communities? Understanding that there are many other behavioral health services that the Department of Community Health administers that we don't have lens into specific to that utilization.

So I'm always having to look at data with those caveats.

Q I want to just make this really concrete, because I know sometimes it can be amorphous.

I'm going to pull back up the list of services that we discussed from the State's supplemental response --

A Sure.

Q -- interrogatory No. 17. Give me one second.

So let's take a concrete example. First of all, do you see the document?

A I do.

Q Okay. This is, for the record, Exhibit 8 previously introduced.

I want to take a concrete example here. Let's choose one that you have familiarity with, I imagine, which would be youth peer support.

Is that a service you're familiar with?

A I am.

Q Do you review data with respect to the availability of youth peer support in Georgia?

A I do.

Q And what data do you review?

A I review data for utilization, so claims submitted for those services. But only for the small subset of covered lives for which DBHDD has some authority for.

Q And how small is this subset of --

compared to the overall number of children receiving Medicaid funded services in the state?

A So we serve approximately 10,000 youth a year, but many of those are served in a brief eligibility type. So, for instance, a youth can approach one of our providers and he or she has no coverage for Medicaid, and we have policy that says if that youth is uninsured, that the agency will assist them in making an application to CMO Medicaid, at which point then our coverage ends, right.

So sometimes we are the covering authority for some of those 10,000 youth, for sometimes only anywhere from four to six weeks. Before then they become enrolled in a CHIP Medicaid plan.

So the numbers are higher than the scope of coverage might suggest.

Q Understood. Just to go back to my question, what is the overall population of children receiving Medicaid funded services, behavioral health services in Georgia?

A I do not know that answer because that Medicaid data is separate from our department's lens.

MS. COHEN: Patrick --

Q Is this -- is the statement you made with respect to your review of utilization data specific to the youth peer support group service true for all of the other services identified in the State's response to supplemental Interrogatory No. 17?

A Yes. The same conceptual framework applies to all of these services, in that we only look at utilization data for that which our department has had coverage responsibility.

Q Have you ever requested data from DCH about utilization of any of these services outside of DBHDD's small subset of --

A As the chairperson of that work group that I indicated under the IDT, I have. But not in the role as DBHDD.

So DCH is pretty clear with us that our authority does not extend into the CMO practice. So in my role at DBHDD I have not seen or requested that data.

In my role as a chairperson of a working group of IDT, focused on behavioral health mapping, I have been a partner in requesting that information because it is for a System of Care request for all of the collaborative state agencies who participate in IDT.

Q And what specifically did you request in your capacity as a member of the IDT?

A So for the financial mapping process we requested claims data from the CMOs.

Q Claims data capturing utilization of each of these services?

A And others. So it would be -- the IDT is interested in the whole of Medicaid services for behavioral health purposes, and so services beyond this would also have been requested.

Q What was the collection period for this claims data that you requested from the CMOs?

A It was for a year, fiscal year '19, if I recollect correctly, because we were trying to look at pre-pandemic practice, and look at a whole year that would be kind of unimpacted by the PHE.

Q PHE?

A The Public Health Emergency.

Q Thank you.

Is that data, the claims data you just described for the CMOs, in hand? Have you received it?

A No. We had -- there was a struggle in the initial report, and we had to modify that data request. So it was not able to be provided to us at

that level of granularity. We had to get it rolled into some bigger buckets.

So, no. The way we requested it is not in hand.

Q What was the struggle from the initial request that you referenced?

A I'm not sure what the struggle was. I know what the output was.

So the initial output, there was a report provided to the co-chair and myself and the COE team, and we didn't feel like it had face validity based on what we understood of the system. And so we regrouped and went back to the Medicaid agency with some questions about, are you sure this is right?

And we let them go back in-house to have whatever dialogue they needed to have, and the counter response to us was, this is the way we can make this available, kind of in these big buckets in this way.

So I don't know what the, what the dialogue or the issue or the challenge was in the background. We didn't make that our business. We were just really totally focused on getting kind of product and output so that we could look at that

against all other payor sources as well.

Q And what year did you receive this initial output, which you testified did not have face validity?

A It was either this year or late calendar year '21.

Q Okay.

A It's been quite recently.

Q And who provided that output to you? Was it someone at DCH?

A Catherine Ivy and Daphne Keit, who is one of their data leads. K-E-I-T.

Q Thank you.

So I want to go back and ask you about the utilization review you do. We can stick with our example, which is youth peer support.

A Uh-hum. (Affirmative.)

Q So what are you looking for in your review of that utilization data?

A So, for instance, youth peer support is a young service. So you picked an example of a service that's quite young.

So for our office what we are looking for is how many providers have enrolled, the geographic location of those providers. And, for instance,

parent and youth were implemented at the same time for -- to be the -- the target is the young person. Parent/youth peer support could support both, the parents and that young person who is targeted.

So we would also be looking to see if both were being rolled out for them because it's called a diab model, where two things kind of come together to support the whole family.

So that's the type of utilization result that I'm looking for. Medicaid -- again, that meant the other Medicaid, the other Medicaid data. The CMO data is not in our lens. So it's not a whole picture but it helps us kind of do a barometric read for is the service getting out there, are providers hiring these peer specialists, and are they beginning to implement it.

And if it's slow or lagging, what might we do in terms of some grants on behalf of DBHDD, some technical assistance, or whatever it might take to be sure that's lifted up to full implementation.

Again, that service was one that was ruled out in late 2017. So very new. So when I look at utilization for that one in particular, I'm looking for are we moving toward some statewide access.

Q So I'm trying to understand what this

review, given its limited scope, per your testimony, would tell you about statewide access, given that it excludes claims for CMO reimbursed services.

A Sure.

MS. HERNANDEZ: Object.

You can answer.

A That is -- it is a challenge, but for us -- again, that's why it's kind of narrowly focused to do we see GEO access? Do we see providers statewide? Do we see a provider at least in each regional area, that kind of thing, and if not, then what can we do to lift that up?

Where we see -- like we knew we were rolling this service out in fall of 2017. We did some initial scan of our provider network and saw that it was pretty low, and then we took that actually in ACER as an agenda topic to talk about expanding that and had some presentations on that, but we never knew what the yield is ultimately for that in the absence of that data.

Q I'm wondering if you could pick out an example of an older service? So I know you identified youth peer group as a younger service.

A Sure.

Q What would be an example of an older

service on this list?

A Sure. Like family outpatient service. That's a very traditional service. It's been part of Medicaid's plan since the 1970s or '80s.

Q Okay. That's a great example.

How does your review of utilization data specific to that service differ at all, if at all, from what you do for youth peer support?

A Sure. There's much more maturity for that service for sure, but one of the things that then we look at still is the geo access, is it accessible everywhere, and we at DBHDD know that answer to be yes because we contract with the Community Service Boards and we require them to do that service.

So we have some additional assurance. So I don't have to look at deeply about geo access with that. I am interested in choice, right. So that there's always choices.

So we would look to see if there's like providers in all the geographic areas to cover, you know, and having choice, right. So I can kind of say 159 counties are covered because of the CSBs, because DBHDD requires them to do this, but then I look at other providers to be sure that there are some choice operating in play. So that.

And then you look at different things, again according to different services. For young people, if I were separating utilization trends for youth, I'm going to want to see almost as much family happening as individual because I need the family to be educated about what he or she -- what his or her's plan needs are. I want the parents to be trained. There's family training service, and there's a family counseling service.

You see those. They are three apart on your list.

Q Uh-hum, I do see that.

A And so we want families to be educated. We want them to understand about what is, what is SED, back to that acronym. Do you understand medication treatment? Those types of things.

So then I'm wanting to look to see that there is a lot of family work going on for youth as well, and I don't know then how the CMOs would look at that one. You know, I'm hoping they would look at that with the same philosophical lens.

Q Understood. Are you familiar with the term "amount, frequency, duration" in the context of Medicaid services?

A Uh-hum. (Affirmative.)

Q Yes?

A Yes.

Q Are you looking at the amount, frequency, and duration of services provided for each of the services listed here?

A Amount, yes. Less frequency and duration. Just because of bandwidth. Not because it's unimportant in any way, but just our utilization capacities haven't been looking at duration and frequency as often.

Q Okay. So the amount would tell you how many units of service were provided, correct?

A Yes.

Q But you wouldn't know necessarily from that data the frequency or duration of services received by any individual child?

A We look at average per -- average per youth, which gives some sense of frequency, but we don't necessarily look at duration, and again those metrics are a lot more complicated because, again, for our covered lives, many of them we're just seeing really briefly before they change plans. They actually access coverage, so it really skews our data because often they are coming in and we see that they get assessment and they might get an

individual counseling or physician's assessment, and then they change coverage to a CMO.

So even though -- what we call case mix, we actually look at what's called case mix, which is like a service pie chart, where we look at kind of what's the average that someone is getting.

And for youth, we always have to have in mind that we have that set of youth who transitioned rapidly to another coverage group, and so they're getting kind of that first set of services that are delivered, but then we don't see the whole clinical picture because they've moved in coverage.

Q Understood.

Did you as part of your request for CMO data, in your capacity as an IDT member, ask for data that would show amount, frequency and duration of services?

A Our original request, which would have been a whole claims extract, would have given us the capability to do that. It was not one of the goals of the map. It was a financial mapping and use mapping. So that wouldn't have been our goal.

The original request could have told that, but the data that ultimately came over, we could not have done a study like that related to that data.

It was just too, too high level, too rolled up to be at that granular --

Q The output that you got --

A -- level.

Q -- was too high level?

A Yes.

Q And you're not -- and you've revised the request now?

A Uh-hum. (Affirmative.)

Q Is that correct?

A We didn't revise the request. We asked Medicaid for certain information, received it, questioned the validity, asked them to go back, check the validity and reliability, at which point they came back and said you're right, there were questions about this, we can provide it in this manner, and they provided it.

But it is a very macro, high level, what I would call a rolled-up utilization into four large buckets, like outpatient, inpatient, residential, et cetera.

Q So the output that you received, correct me if I'm mistaken, doesn't break down service data specific to youth?

A It is specific to youth.

Q Okay, that's right.

A But it is not specific in any way to these subline items.

Q Okay.

A And it is not claims level detail.

Q Are you waiting -- just to kind of close the loop, are you expecting to receive any more data or information in connection with the request you made to the CMOs?

A No, not right now. We're kind of settling into what we've got and just not letting perfect be the enemy of good at this point. So we are moving ahead with what we have, and there's no additional request at this point in time.

Q If you had more staff working directly under you, would you want to be looking at amount, frequency, and duration for each of the services listed on this exhibit?

MS. HERNANDEZ: Objection.

You can answer.

A Certainly -- yeah. I mean I'm a policy wonk, so. So this is -- my subjective answer, of course.

The role and functionality and the way the system is designed at this point, it's not our

functional role to do so because that's all been carved out. Now, again, you know, in a -- in a world where there was a lot more transparency and transactional data and information, that would be lovely to have a good snapshot of that behavioral health content.

Q And is it -- when you say "snapshot," are you talking about a comprehensive snapshot across both CMO reimbursement and DBHDD reimbursement?

A It would certainly tell us a lot more about the public sector behavioral health system, certainly. It's just impossible to answer that any other way. It would be a bigger snapshot, more comprehensive snapshot.

Q And again this is just to make it clear for the record.

You said that during that comprehensive analysis is just not your functional role at this point?

A Right.

Q Is it DCH's functional role?

A DCH --

MS. HERNANDEZ: Object.

You can answer.

A DCH doesn't have authority into our data

either. So it would not be their functional role to look at uninsured claims.

Q So there --

A There's no --

Q I'm so sorry. I didn't mean to interrupt you. Go ahead.

A They have no authority over that either.

Q Is it fair to say that there is no single state agency within the State of Georgia that is looking comprehensively at provision of community behavioral health services in Georgia?

MS. HERNANDEZ: Objection.

You can answer.

A That's subjective as well. So I'm just measuring, measuring my statements.

There are efforts underway recently to try to bring some more of that information together. The IDT is identified in law, under the System of Care law, to bring some of this together for children, but it is not a state agency.

It is -- there's some purview given to the DBHDD to look at this information, but it is not set forth in law the way to garner all of that data or pull it all together. So it becomes then a function of these subcommittees and of asks instead of there

being kind of a singular mandate related to that having a hub right now for the system.

Q Okay. I just want to make sure your testimony is clear. Is there any other entity aside from DBHDD that is assessing access to community behavioral health services for DBHDD grantees?

MS. HERNANDEZ: Objection.

You can answer.

A When you say DBHDD grantees --

Q I --

A -- do you mean the beneficiaries?

Q I do, yes.

A Okay, okay.

Q Let me, let me -- let me go ahead and restate the question because it will be clear this way.

Is there any other entity aside from DBHDD that is assessing provision of community-based behavioral health services to DBHDD beneficiaries?

MS. HERNANDEZ: Objection.

Can you answer?

A No.

Can I add a caveat to that?

Q Yes.

A I want to be sure that for the uninsured

that answer is no. For the Medicaid beneficiaries who fall into the aged, blind, disabled category, as I articulated earlier today, there's a joint collaboration process.

So the Department of Community Health could very well look at utilization for our shared population, those who are Medicaid as a result of being aged, blind, disabled in accordance with that federal policy.

So they could indeed have some oversight to that subline of eligibility, but they would not have any authority or oversight to the uninsured line of eligibility under our department.

Q So DCH's review of provision of community-based behavioral health services to children is incomplete, just as DBHDD's review is incomplete?

MS. HERNANDEZ: Objection.

You can answer.

A That is at least my lens on that, yes.

Q So I'd like to show you another exhibit.

I'm going to stop sharing this. So this would be 142.

(WHEREUPON, Plaintiff's Exhibit-142 was marked for identification.)

BY MR. HOLKINS:

Q I'm note for the record this email was produced by the State of Georgia to the United States in this litigation as GA04301608. It's an email that include an attachment, which I'll also be showing you as part of the same exhibit.

I'll give you a chance to review the email.

A Okay.

Q Give me one second and I'll give you control.

You have control.

(Witness reviews exhibit.)

A Okay.

Q So this is an email, if I'm not mistaken, sent by Tricia Mills to you and a number of other recipients, dated May 4th, 2020. Is that correct?

A Correct.

Q Who is Tricia Mills?

A Tricia Mills was a program director who worked under Dante McKay in his division -- his office under the Division of Behavioral Health, and she's no longer with the Department, but she oversaw some specific programs for Dante.

Q My understanding of this email, and

correct me if I'm mistaken, is that Tricia Mills is sending you a statement of need in connection with a service supported education/supported employment.

Is that accurate?

A That's accurate.

Q Her email indicates that you and John -- who I'm guessing is John Quesenberry?

A Correct.

Q -- met with Tricia Mills before she sent this email --

A Sure.

Q -- to discuss the service?

A Yes.

Q So I'd like to now pivot over to the attachment.

Do you see the attachment?

A I do.

Q This is GA04301611. It's a part of Exhibit 142.

Would you like to take a moment to review the document?

A I know it's quite long. I remember the gist of it, so.

Q That's fine.

A If you just wanted to highlight. Yeah, I

recall the document. If there's anything in particular I need to skim or scan as you go, I will feel comfortable doing so.

Q So what I wanted to direct your attention to is the introduction, which starts on Page 1 of the document.

MS. COHEN: You're referring to Page 1? 611 is Page 1?

MR. HOLKINS: Yes, 611.

MS. COHEN: Thank you.

BY MR. HOLKINS:

Q The second paragraph under 1.1, Purpose of Statement of Need, reads: "Although Georgia has made significant improvements to its children's behavioral health system over the last few years" -- excuse me -- "past few years, opportunities remain for state agencies, providers and communities to further improve the delivery of children's behavioral health programs and services. Children's behavioral health challenges continue to present at home, school, and community settings. Children and families, particularly in rural areas of the state, still face difficulties in accessing basic and specialized children's behavioral health services."

Do you see that text?

A I do.

Q I want to direct your attention to the last line I read: "Children and families, particularly in rural areas of the state, still face difficulties in accessing basic and specialized children's behavioral health services."

Do you agree with that statement?

A I do.

Q And what challenges do children and families, particularly in rural areas of the state, face in accessing basic and specialized children's behavioral health services?

MS. HERNANDEZ: Objection.

You can answer.

A I mean I think the biggest challenge we are experiencing right now is prior to the COVID-19 Public Health Emergency, we had 151 of 159 counties that were behavioral health professional shortage areas. So while we do our best in recruiting provider agencies, there are still access challenges related to the workforce, and those have been exacerbated by the pandemic.

So at the time when this was being written, we knew distinctly about the behavioral health workforce challenge, and also given the time

that this was written, also understood that telehealth still was a challenge in the -- in terms of access through kind of broadband communications and the like.

Q What specific basic or specialized children's behavioral health services are children and families struggling to access?

MS. HERNANDEZ: Objection.

You can answer.

A So in this case, this particular statement of need, the rollout for these services that Ms. Mills was defining are supported employment and supported education, neither of which are Medicaid covered services.

So these were targeted. This, this particular response is indicating that we are aware that these services were not available and we were seeding them for the first time for these young people.

Q I understand that you're speaking about this document.

A Uh-hum. (Affirmative.)

Q I'm asking you more broadly.

A Okay.

Q What are the gaps in either basic or

specialized community-based behavioral health services for children and their families?

MS. HERNANDEZ: Objection.

You can answer.

A If I could target one thing right now, it's the workforce. And so it is -- we're in a kind of critical time related to the numbers of practitioners we have and being able to meet the needs of young people in terms of access, and that is not just a Georgia issue, that's a national challenge right now as we're experiencing it.

Q So we're going to do this another way. Let's take a look back at Exhibit 8, the State's supplemental response to Interrogatory No. 17.

Let's start at the top of the list. Do children and families have adequate access to behavioral health services in the State of Georgia?

MS. HERNANDEZ: Objection.

You can answer.

A For an initial -- let me just caveat. Right now, because of the behavioral health workforce challenges, I think there is a global challenge with accessing behavioral health services.

Q I'm not asking about a global challenge. I'm asking about challenges in the State of Georgia.

So let me ask again.

Do children and families in the State of Georgia have adequate access to behavioral health assessments?

MS. HERNANDEZ: Objection.

You can answer.

A I think yes. I do. Again, that's -- that is largely pandemic related right now, and so I just -- I don't think there's a better way to answer that.

I think for all of these services, there are access challenges right now in Georgia.

Q Okay. For all of the services listed in the State's Supplemental Response to Interrogatory No. 17 there are access challenges, correct?

A Yes.

Q And you state this without having reviewed utilization data in connection with Care Management Organization refunded services, correct?

A Correct.

Q What specifically are the access challenges with respect to Intensive Customized Care Coordination?

MS. HERNANEZ: Objection.

You can answer.

A So right now for Intensive Customized Care Coordination, we have identified that we want to expand the provider network, and there has been a statement of need release from Dante's office to bring on new providers for that service, and so it is that hope and expectation that that would again hopefully increase access to that very important service.

Q And has DBHDD set a target for how much it wants to increase access to IC3?

A So we are trying to take the provider network from two to four, and the two we have now, the two providers have statewide coverage expectation.

The two of them cover, though, 159 counties each, and that is like quite a stretch from an administrative management perspective, which is why we identified after this initial go live that we needed to bring on two more providers for that specific service.

Q And do you believe that expanding from two to four providers of IC3 is sufficient to meet the need for the service?

MS. HERNANDEZ: Object.

You can answer.

A It is my hope that it will. The original service, Intensive Customized Care Coordination, again, in the national work that we did and based on utilization trends from other states, there is a small number of young people who medically necessarily qualify for that service, and so taking it from two providers to four is what we hope is going to be a good first step in being sure that we can maintain fidelity, because it does have a high-fidelity standard to the service delivery model, while making it more accessible to young people.

Q Who reviews fidelity with the IC3 model?

A It is individuals who work for Dante in partnership with the Center of Excellence.

Q And who specifically within Dante's staff is working on reviewing fidelity with the IC3 model?

A I --

MS. HERNANDEZ: Objection.

You can answer.

A I know Tricia Mills, while she has left service, she has been on a contract to continue some of that work.

And that Dr. Pearson also has oversight on the global clinical package of content, and they

both meet with the Center of Excellence related to that.

Q Let's go back to Exhibit 142, the statement of need for the supported employment and supported education programs for youth and emerging adults with severe mental illness.

What is the current status of this program?

A I actually haven't had an update on this since it was implemented. So, again, in my narrow scope of capacity in my office, I frequently am in the development stages of this work, just to be sure that it comforts with any necessary Medicaid policy or is considering Medicaid eligibility and coverage, but this service was not targeted for Medicaid, and therefore I've not stayed actively engaged with it.

Supported employment, nor supported education are covered services in the Medicaid package.

Q Are there specific geographical areas of the state that you would identify as particularly in need of additional community-based behavioral health services for children?

MS. HERNANDEZ: Objection.

You can answer.

A I think, again, we are experiencing in our most rural areas, so the southwest and southeast, still some challenges in hiring because of the behavioral health workforce shortage. So if I were targeting an area, those would be the areas that I would be considering.

Q Have you reviewed data or documents showing regional disparities in the availability of community-based behavioral health services for children?

A I have not looked at that particular issue during the pandemic. We have been focused on a lot of other staffing challenges, and so have not -- I have not looked at that in recent months.

Q When is the last time you looked at data showing regional disparities in the availability of community-based behavioral health services?

A It's probably been nine months or so.

Q What's --

A Nine months to a year maybe.

Q Sorry. Thank you.

A I look at utilization quite a bit. We've been trying to be sure that the utilization globally is recovering in the pandemic, and that's where a lot of our energies have been focused most recently.

Q And when you did review this data, where did you get it?

A It comes from the Administrative Services Organization and through, through partnership with John Quesenberry's office, kind of structuring those reports in a way that they are then accessible to our team as managers.

Q So, again, this would just be data that's specific to service provision to DBHDD beneficiaries?

A Uh-hum. (Affirmative.)

Correct.

Q Do you track any data with respect to the utilization of evidence-based practices?

A There are some evidence-based practices that we have highlighted for the COE to do some deeper study and review of, but we do not necessarily capture by IT coding the unique EBP utilization. EBP, evidence-based practice.

So, for instance, the intensive customized care coordination has been a high-fidelity model that we have invested a lot of infrastructure, analysis and support on, and therefore have put into a contract with the COE to study that with rigor, to check that with rigor, to be engaged in looking at

some evidence-based outcomes and performance outcomes related to that service.

So where we have bandwidth and capacity, we do those kinds of deep dives. However, if you think about a service like individual counseling that I mentioned earlier, where there are maybe a hundred ways to deliver an EBP, we can't track it with that granularity, and we don't.

Q What informs your opinion that you can't track it with that granularity?

A So in basic claims data, through like a standard Medicaid claim, there are not national code sets that say -- within the individual counseling code there are not nationally norm codes that would distinguish a service like dialectical behavioral therapy from cognitive behavioral therapy, to functional family therapy, and so on.

So there -- the way that system is designed does not allow that kind of subcoding.

Q Could DBHDD hypothetically survey providers to learn about provision of evidence-based services?

A Yes, we can. And there have been some periodic efforts to do so.

So, again, but that's based on kind of

capacity and bandwidth. So where we've had capacity and funds to say to the COE, can we focus in on this for a moment, we have done those types of surveys. So it is possible. We have done it.

It is not anything that has had the capacity to be sustained for the long haul in terms of budget and management, but we have entered into those types of surveys before.

Q Do you review -- and let's go back, just to again make this concrete, to Exhibit 8, which we've been talking about a lot, the list of services identified in the State's supplemental response to Interrogatory No. 17.

Do you review any data with respect to outcomes for youth who receive these services?

A I do not.

Q Do you know if anyone at DBHDD does that?

MS. HERNANDEZ: Objection.

You can answer.

A I do know that our performance group that I mentioned earlier, under our division, is designing new kind of outcomes, oriented constructs to be able to look at some of this content but, again, that is just emerging and it is again -- it would have to be DBHDD focused and not whole system

because of the CMO data being separate from our entity.

Q And the division that is creating these new kind of outcome measures, that's the division under Melissa Sperbeck's control?

A Yes, correct.

Q Do you know whether that group as part of this assessment of outcomes will be looking at whether youth who receive these services end up in GNETS?

MS. HERNANDEZ: Objection.

You can answer.

A I'm not aware of any dialogue related to that, not at all.

The national HEDIS metrics, healthcare metrics that are available, don't really focus on that type of content. So that's been a guiding force in what we've begun to think about related to outcome measures. So it is still very preliminary.

Q Could you just make sure for the record, the national metrics, could you explain what those are?

A HEDIS, H-E-D-I-S, and I can't even bring to mind what that stands for, but it is a very nationally normed healthcare set of metrics which

focus on some real process oriented outcomes. At this point it's kind of the state of the industry. So, for instance, when a young person leaves inpatient care, do they get an outpatient appointment in seven days. Very high level, global national metrics that are mandated across healthcare providers.

Q Thank you.

So I'd like to pivot to another exhibit. I'll note for the record this document was produced by the State of Georgia to the United States in this case. The Bates number is GA05027310, and I'm introducing it as Exhibit 143.

(WHEREUPON, Plaintiff's-Exhibit-143 was marked for identification.)

BY MR. HOLKINS:

Q I would also note for the record that this exhibit was marked confidential by the state, so we'll obviously take measures to maintain its confidentiality in the record.

MS. COHEN: Well, that said, is the State going to take the position that the testimony related to this exhibit is confidential?

MS. HERNANDEZ: I don't believe so, no.

MS. COHEN: No. Okay. Then -- thanks.

MR. HOLKINS: Thanks, Frannie.

MS. COHEN: And then does that apply to the exhibit as well?

MS. HERNANDEZ: The exhibit itself is confidential.

MS. COHEN: The exhibit is confidential but not the testimony?

MS. HERNANDEZ: As long as we don't go into the personal information of these individuals listed on these.

MS. COHEN: Got it.

MR. HOLKINS: Understood. I won't.

I'll just note for the record this document is titled, "Approved Medicaid Provider List - Behavioral Health," in parentheses, "(C&A) Active As of 03/01/2020," and the top left corner is the text "The Georgia Collaborative ASO."

BY MR. HOLKINS:

Q Ms. Tiegreen, have you seen this document before?

A I have.

Q Do you regularly review a list of approved Medicaid providers?

A I do not. Not in this format. I see the

list of providers on utilization tables.

So when I look at services, I can see all the providers doing the service. I don't look at a table like this that has this level detail with any regularity.

Q You did look at this specific list, though, correct?

A I did.

Q Before today?

A I have seen this before.

Q For what purpose?

A I think it was in response to this request.

Q By "this request," what do you mean?

A The interrogatories having been copied. I mean I'm not sure if that's what this was from, but I've seen a list quite similar to this that was a response to some interrogatories.

Q So I take it you're not looking at this exact format with any regularity?

A Right.

Q But you say you are looking at lists of --

A Service providers.

Q Okay.

A Related to services.

Q And just so I'm clear, what is the purpose of looking at a list of approved Medicaid providers in this format or any other on a regular basis?

A So there's a benefit to knowing where providers are located and to where they're serving.

In this case, this is too limited by having a mailing address to be beneficial to think about access. But when you look at a regional utilization chart, you can see services and providers.

So while a hardy list is fine. If they only serve a three-mile square block, it's not beneficial.

Q You reference regional utilization charts; is that right?

A Regional utilization, correct.

Q Is that a document that you're accessing regularly?

A It's not a standard document that we use. It's just been periodically pulled before.

Q Pulled from where?

A So, again, the ASO can do any specialized reports to look at any special requests that are made by leadership, in as much as the bandwidth is available.

Q So you would be, if I'm not mistaken, making an ad hoc request to the Georgia ASO Collaborative for a list of Medicaid -- approved Medicaid providers --

A Correct.

Q -- correct?

A And it is mostly our regional offices who have some responsibility and purview for that.

So under Dante's leadership, he has regional staff who look at regional content related to that access, and then they in particular bring any access issues back through him as well.

So it's not just my responsibility. There's actually regional staff who have a lot of responsibility in this particular area.

Q You're referring to the DBHDD regional offices, correct?

A Correct.

Q Is it accurate that the list of approved Medicaid providers that you're reviewing on an ad hoc basis is limited to what's given to you by the Georgia Collaborative ASO?

A Yes. For our body of business.

Q I'm going to give you control of the document. I'm just curious whether you can scroll

through it and let me know whether there are any schools identified as approved Medicaid providers on this list.

(Witness reviews exhibit.)

A None that I would recognize as functioning in that manner.

So, again, here's where my lack of knowledge of LEA programs is hindering my response more accurately. If an LEA was functioning within a school, with like a different naming convention, I wouldn't recognize that. But most of these providers I know and are not schools.

Q Mostly the providers are Community Service Boards and other direct provider organizations, correct?

A Correct.

Q Do you recognize any names of schools on this list?

A I do not.

Q Do you recognize any names of school districts on this list?

A I do not.

Q Do you recognize any names of LEAs on this list?

A I do not.

Q Set this aside.

Do you track any data with respect to the number of students receiving mental health services who are admitted to PRTFs?

A I do not.

Q And let me reask it a different way.

A Can I -- yeah.

Q Do you track any data with respect to the number of children admitted to PRTFs?

A I do, and for the states it's very low.

We have just completed a two-year study with the Department of Community Health where we worked collaboratively to look at some PRTF utilization. So for the past two years Dante McKay and myself have both been involved with the Department of Community Health, where we've actually been able to see some CMO utilization data specific to PRTF as well.

So we have been looking at PRTF utilization in a much more studied manner as a result of some requests from the PRTF to do some additional analysis of that service.

Q So let me try to understand correctly.

You're accessing CMO data with respect to PRTF utilization?

A Accessing it and the CMOs are providing it and bringing it to the DCH. The DCH is bringing it to meetings with our department to look at more global PRTF utilization.

Q So this is in response to your request by DBHDD?

A This is in response to a request from the PRTFs.

Q Are the PRTFs operated by DBHDD?

A They are not.

Q They're all private?

A They are all private.

Q Are they licensed by DBHDD?

A They are not. They are licensed as specialty hospitals by the Department of Community Health.

Q Okay. Does DBHDD have any direct oversight responsibility with respect to the PRTFs?

A We have oversight as related to our covered lives. So we have policy procedure, admissions, parameters set forth with the ASO, just like we do other services, but that does not give us authority over the PRTFs.

We purchase the service on behalf of our beneficiaries, and we do so, though, in accordance

with medical necessity standards and expectations that are set forth in their contracts or in policy that they are asked to adhere to via those contracts.

Q Does the data that you've received with respect to PRTF utilization show how many youth are referred to PRTFs from GNETS facilities?

A No.

Q Would you be able to access that data?

A No. Not without something like you were just saying, which would be a very specific targeted survey. It's not sitting somewhere and we're just not pulling it, to be more specific to your question.

Q So I have just a couple more documents I'd like to get through in this line and we'll take a brief break, if that's all right.

A Okay.

Q So I've just produced what I'm introducing as Exhibit 144.

(WHEREUPON, Plaintiff's Exhibit-144 was marked for identification.)

BY MR. HOLKINS:

Q For the record, this document is identified as GA04298133. There's an attachment to

the email that we'll be including in the exhibit, and we'll discuss that separately.

I'll give you a minute to review the email chain. Give me one second.

You should have control.

(Witness reviews exhibit.)

A Okay.

Q So this is an email from you to Melissa Sperbeck, dated April 14, 2020, with the subject "Re: DCH Paper."

Is that correct?

A Correct.

Q And you're attaching a document entitled, "DBHDD Proposal for DCH 2020 04 14 wwt." Correct?

A Correct.

Q We're going to take a look at the attachment now and we'll discuss it. Give me one second.

For the record, this is GA04298134, and it's being offered as part of Exhibit 144.

I'll give you a second to take a look at this document.

A Thank you.

Q You have control.

(Witness reviews exhibit.)

A I apologize. It's a long document, so I'm just taking a minute.

Q Take your time. My questions will just be on a few specific pieces toward the top of the document, but you can take all the time you need to review it.

(Witness reviews exhibit.)

A Okay. There are several attachments which helped me move more quickly to the end. Thank you.

Q You're welcome.

So I'm taking back control of the document. I'm going to scroll to the top.

My understanding of what this is is a draft of a state plan amendment prepared by DBHDD for review by DCH during the COVID-19 emergency. Is that correct?

A Yes. And I want to be clear that the disaster state plan amendments had very particular parameters around them to be responsive to the disaster. And so I just think that is probably important to say in the context for this, and this was very early on. As you can see, we're just a month into the declared public health emergency and, yeah, Federal Medicaid was just trying to help states at this point, as you see from the

attachments, trying to help states figure out what pathways it would and could implement through a state plan that would be specific for disaster response.

Q Thank you for that clarification.

So I'm going to point you to some specific lines in this draft, but let me first ask you, what were your contributions to this document?

A So I'm the primary, primary author of the document.

Q The first sentence on Page 1, and again this is GA04298134, which is part of Exhibit 144, the first line reads: "DBHDD serves as the day-to-day operating authority for the DCH category of service (COS) 440 and the sole administrator for state funded behavioral health services."

My question, my first question is, what is DCH category of service 440?

A That is the community behavioral health rehabilitation services numbering. So category of service is how Medicaid numbers different programs in its purview.

So this becomes -- this emanates from the state plan chapter called the Medicaid Rehabilitation Option, which locally is called

CBHRS.

Q Okay. So this category of service would encompass the rehabilitation services on Georgia's state Medicaid plan?

A It encompasses the subset of services that is in the list we were previously looking at in the interrogatory.

Q Okay. That's very helpful.

So toggling back to Exhibit 8, you're referring to this list of community-based behavioral health services identified by the State?

A Correct. These are the only services that are in category of service 440.

Q And so this statement is accurate, that DBHDD is the day-to-day operating authority for that full list of services?

A For that full list of services for -- notice the very last statement -- for individuals covered in Medicaid fee for service, which is the other, the other term, the other language used for Medicaid aged, blind, disabled.

So we are not the day-to-day operating authority for any of those same services when they are provided by the managed care organizations.

Q I'm confused, though, because -- let me

phrase this as a question.

The last line is referencing paying for state match for those services, correct?

A Correct.

Q The first line, if I'm not mistaken, just says: "DBHDD services the day-to-day operating authority for the category of service 440," which you stated includes all of the services identified in the State's response to Interrogatory No. 17, correct?

A Except for Medicaid then delegates sub-authority to the Medicaid managed care companies for those services when they are provided to those other beneficiaries.

Q But if DBHDD serves as the day-to-day operating authority and the sole administrator for state funded behavioral health services, how is that DCH's authority to delegate?

A Medicaid has authority for everything that Medicaid oversees. So in this scenario what, what we were saying to the Medicaid agency is, is we, we are your partner and administrator for these services. That shouldn't be construed as meaning that this statement subsumes and takes over all the other authorities that are already in place.

So law says that we are the authority for state funded behavioral health services. Law also says that Medicaid is in charge of all of Medicaid services. So there's overlapping authorities in that scenario.

So Medicaid in that case has other authorities that it can also exercise.

Q Let's take another -- let's take a closer look at what Georgia law says.

I want to turn to Page 3. I'm specifically looking at the bullet that starts "In Georgia Code."

Do you see where I am?

A I do.

Q It reads: "In Georgia Code," in parentheses "(Section 37-1-20) DBHDD is charged," in quote, "to provide an adequate array of services and choice of providers for consumers.' And, in quote, 'to establish a system for local administration of mental health, developmental disabilities and addictive disease services in institutions and in the community."

Further, in quote, "The department designated and empowered as the agency of the State responsible for supervision and administrative

control of programs for the care, custody and treatment" and then it goes on, ultimately in quote.

So what is your interpretation of this statutory language with respect to DHBDD's mandate?

MS. HERNANDEZ: Objection.

You can answer.

A So in this document -- this is a proposal to DCH. So we did not also define DCH's role. We didn't take the prerogative to define their role, which is overlapping to ours, which says they are in charge of all healthcare services for Medicaid beneficiaries.

So in this -- this is what I would call, right, this is a proposal. It's our pitch paper, don't forget us, DCH, as you make a proposal on a state plan amendment related to COVID.

So this is reminding them of our authorities, understanding and not taking away their authority, which is not named herein, that they are in charge of all healthcare for Medicaid beneficiaries, behavioral health and other.

So we have in law some concentric responsibilities for the same beneficiaries.

Q How do you interpret the phrase which you included from Georgia Code, "The DBHDD is charged to

provide an adequate array of services and choice of providers for consumers"? What does that mean, in your view?

MS. HERNANDEZ: Objection.

You can answer.

A In my view -- in my view, as an employee of the behavioral health authority, that would presume that we have some of this power.

The co-existing other law gives Medicaid that same footing and therefore creates this dynamic relationship that I was alluding to at the beginning of our conversation, that neither is fully the authority as long as there is concentric overlap for many of those covered lives, and in some cases by executive design then some of this has been pulled away from the behavioral health authority and given to the CMOs to set medical necessity, to set systems, to say whether or not there's an adequate array of services and choices for consumers. That also sits with the Medicaid agency separate from our department for the managed care covered lives.

So there's, there's the law, and then there is how this plays out in administrative functionality.

Q Would it be fair to say that DBHDD and DCH

share jointly the responsibility providing an adequate array of services and choice of providers for consumers of community behavioral health services?

MS. HERNANDEZ: Objection.

You can answer.

A If you think about the whole of public beneficiaries, in large part DBHDD and the Medicaid agency together cover all of those lives.

Q I want to direct you to some stats, statistics, that appear in this document, specifically on Page 1 of GA04298134, part of Exhibit 144.

The second-to-last bullet reads: "Georgia is ranked 47th in the country for per capita spending on mental health."

Do you see that stat?

A I do.

Q What is KFF.

A Kaiser Family Foundation.

Q Have you seen updated rankings from --

A I have not.

Q Let me just finish the question.

Have you seen updated rankings from KFF with respect to Georgia's per capita spending on

mental health?

A I have not.

Q One more document and then we'll take a break.

So I'm showing a document that is part of the next exhibit, 145.

MR. HOLKINS: 145.

(WHEREUPON, Plaintiff's Exhibit-145 was marked for identification.)

BY MR. HOLKINS:

Q This is an email produced by the State to the United States, marked GA04288334.

It's an email from you dated January 23rd, 2020, sent to a number of recipients.

I'll give you a minute to review the email. Please let me know when you're finished.

A It's very short. I was able to look at it while you were talking.

Q Great.

A Thank you.

Q Thank you.

The subject of the email is "Document2 - Compatibility Mode."

In the body you reference a "product we use to recommend the right design for Foster Care or

Managed Care when DCH took this back."

First off, what did you mean when you said "DCH took this back"?

A So prior to 2007-ish, the children who were covered by Medicaid, who also had -- who were foster care enrollees, they were covered by a Medicaid program called TRIS, the Therapeutic Residential Intervention Services plan.

It was a different category of service, a different program manual for Medicaid, and at some point there was some federal review of the program, and federal CMS asked the State to change the design model. All of the money for that program was collaboratively managed up until that point by the Division of Family and Children Services with the Department of Community Health.

When the corrective action response was sent to federal CMS, what was decided on by the State was that foster care children would no longer be covered through an interagency working agreement between Child Welfare and Medicaid, but they wanted to bring more medical credibility, they wanted to bring external review to bear, prior authorization. And so the executive team for the State, including the Governor's Office, made the recommendation that

DBHDD begin to manage the foster care covered lives.

We assumed that in 2009-ish or so, and about two years later it was decided that it was best to take foster care into a whole health model and to put it all into managed care, to be procured to a managed care company and managed by a single CMO.

So the -- what is it, take it back? Or when DCH took this back, that comment is DCH and child welfare managed it together. Briefly it was transitioned as part of the corrective action plan for DBHDD, and Medicaid to collaboratively manage, and then Medicaid took the funds assigned to foster care back into their budget to pay for a procurement product, contract with the winner, proposal winner, who was Amerigroup.

Q Okay. Did you draft the attachment that you reference in this email?

A I did.

Q Let's take a look at it.

MS. COHEN: Is this 145?

MR. HOLKINS: Yes.

MS. COHEN: What's the document number?

MR. HOLKINS: The document number for the email is GA04288334.

MS. COHEN: Thank you.

BY MR. HOLKINS:

Q This is the attachment part of Exhibit 145. The Bates number is GA04288335.

Is this the document that we just discussed that you drafted and attached to the email?

A Yes.

Q It's dated November 1, 2002. It's titled "Department of Behavioral Health and Developmental Disabilities Response to Department of Community Health's Call For Feedback to the foster care, managed care issue, right?

A 2012.

Q 2012. Excuse me. The date is November 1, 2012?

A Yes.

Q I want to ask you just about some specific pieces of this, this document, starting with the values that you identify for a youth recovery oriented System of Care.

Do you see those on Page 1?

A I do.

Q Do you have any updates to this list of values for recovery oriented system of care?

A Let me read them for a moment.

Q Please take your time. I'll give you control if you need it.

A No, I'm fine. Thank you.

(Witness reviews exhibit.)

A These are very far-reaching philosophical statements, so I might could wax further philosophical, but I don't see anything that's missing.

Basically, I still see these as the guiding tenents for a recovery oriented system of care.

Q Speaking broadly, what is the value of, of recovery oriented system of care for you?

MS. HERNANDEZ: Object.

You can answer.

A Thank you.

A recovery oriented system of care recognizes the complexity of the impact of a behavioral health condition. That it impacts friendships, it impacts family relationships, it impacts school performance, it impacts general healthcare and wellness. It impacts sleep. It impacts exercise.

And so the complexity of the condition,

that it yields a response that brings together entities and agencies who may have a vested interest in a young person in a way that gets quite complicated for the child and family.

And so a system of care, to just take that phrase, contemplates the idea that providers and formal supporters, such as state agencies and the like, should come together to work collaboratively on behalf of the youth and the family.

The recovery oriented part of this is about focusing on the child and family strengths, not the deficits, and working towards an outcome end without being bogged down into the symptoms and the functional challenges of the young person.

So approaching the young person from a space of you can get better, people with the same condition get better, there is hope, there is high expectation of your wellness, and leaning into it in a positive framing, while bringing together that collaboration, which then is about all these systems may be involved in working with you but let's really create a space where those systems are working together.

The one other thing I would like to say is just, for the record, I know it's identified in

Paragraph 1, but this is a product that I chaired through which many voices sat at a table, such as this, and said we want to design kind of the epitome of what this product would look like. And so it is my fingers again at the keyboard but listening to the voices of several of the partners who are acknowledged within this document.

So I want to say while you ask me did I write this, yes, I did. I wrote this, though, with a collaboration of leadership and advocates.

Q Are you referencing the first paragraph, the meetings between DCH, DBHDD, DCFS, DJJ, and DPH?

A This -- and the partners at the top. So it says as a component of the partners' ongoing dialogue. The partners also included representatives from some advocacy organizations and some provider organizations, as you see about three lines into that first paragraph. This paper represents discussion between.

So it was multiple partners who came to the table to share a vision about what we wanted to offer in this particular time as this was being designed.

Q Okay.

A So while, while you're asking me some very

specific things about the paper, I also want to represent that it was not a DBHDD product. It was a -- it was DBHDD facilitated through the person of me, but it was a pretty sophisticated group of partners who had some investor interest in youth and foster care.

Q Well, thank you for that clarification.

Let's skip down to the next list, also on Page 1 of this document.

If I'm understanding you correctly, the bullets under Behavioral Health Services and Supports Musts are identifying what you, in collaboration with these partners, identify as the key components of a recovery oriented system of care for youth. Is that accurate?

A We are setting our wish list through this paper to the Department of Community Health in designing their procurement.

Q And is this -- is this wish list, I guess as you use the term, have applicability broadly to community-based behavioral health services in Georgia?

A Yes. In Georgia and nationally. So the system of care frameworks are national frameworks, thus some of the citations in the documents that

come from some national global products.

Q Does your office undertake any evaluation of whether or not the elements identified here as components of recovery oriented system of care for youth are actually being implemented in Georgia?

A I wouldn't say a standard evaluation is occurring through my office because it's so tiny. My scope and capacity can't, can't carry that.

However, I am aware that many of these items -- if you think about what we are assessing and evaluating through the Center of Excellence, we are hitting some of the sub-priorities of this through that limited process, to try to give us a sense of whether or not some of this is occurring.

Q What specific components identified here do you understand the COE and DBHDD is attracting?

A So, for instance, Bullet 2, we are talking about linkage and where -- that the support should provide linkage where there's high acuity in providing intensive care coordination using high-fidelity wraparound.

So really wanted the CMO at this time to embark on using high-fidelity wraparound, while also not waiting for that, and putting it into the State plan beginning in 2017, which was some years later,

but we really wanted to seed this in the CMO for foster care at the time because the Care Management Organizations can do early implementation. They can do specialized services implementation.

So we wanted to go ahead and put that in even though it was still under development in the CHIPRA grant that we referred earlier. We knew it was under development but we wanted to go ahead and plant that seed here for that CMO, particularly given the high acuity needs for youth in foster care.

Q Are you aware of any analysis by DBHDD of whether the behavioral health services and supports received by children enrolled in GNETS contain the elements identified here as key components of the recovery oriented system of care for youth?

A I'm not aware of any study that has that set of parameters.

Q I'd like to skip down. Bear with me. I'm going to be searching for some things here.

On Page 2, under No. 5, you reference a state statute. Do you see where I am, O.C.G.A. 37?

A I do.

Q You write: "Our charge is to be a 'visible and accountable leader across state

government - and a skilled resource - integral to the coordination of public behavioral health care across multiple agencies, involving many funding streams and delivery systems.'"

To your knowledge, has that provision of state law changed since you wrote this document in 2012?

MS. HERNANDEZ: Object.

You can answer.

A Not to my knowledge. Again, I would like to state in many cases when we're stating this in documents to the DCH, we are reminding them of that duality in law, that they look at their own law and they're like we're the authority over this whole domain.

So in many cases we are writing as a sister agency about our role in law to be a reminder to them of our functional stance in this dialogue and role, particularly having understood, circa 2006, that the design which was implemented, was we, DCH, are taking the behavioral health components for service delivery for the Medicaid managed care covered lives and we are now delegating to the Care Management Organizations the design, management, and implementation of that behavioral health benefit.

Again, allowed in law by Federal CMS but not necessarily recognizing then the role that's set forth for DBHDD in accordance with law.

So the overlapping authorities then create some of this challenge in role implementation.

Q So I'm going to ask a simple question. Does this statement reflect reality: "Our charge is to be a visible and accountable leader across state government - and a skilled resource - integral to the coordination of public behavioral health care across multiple agencies, involving many funding streams and delivery systems."

Is that statement an accurate statement of reality?

MS. HERNANDEZ: Objection.

You can answer.

A That is our charge.

Q Okay. Let's move on.

In the next page, under General Considerations, the second bullet references Georgia's ADA settlement, the Americans with Disabilities Act, and the Olmstead Act.

The language of the text, the text specifically reads: The state shall ensure that the community behavioral health services system adheres

to expectations set forth in Georgia's ADA Settlement, Americans with Disabilities Act (ADA) and the Olmstead Act."

Do you see that language?

A I do.

Q What specifically were you contemplating when you wrote this?

A So, again, understanding the framework as it was implemented in 2006, the movement of that authority and the governance of that day-to-day work for Medicaid behavioral health that was delegated to the CMOs, in many cases the lens over that was not always contemplative of the settlement agreements that were emerging.

So think about the time of this document, around 2012, the settlement was still relatively new. Olmstead was in place but the settlement was new. So what we were doing here was just reminding the Medicaid partner: Just be sure you are contemplating these expectations that the State holds in the settlements as part of what you consider as you contract with this new vendor.

Q And have those expectations changed since you drafted this in 2012?

A They have not.

Q And what specifically are your expectations with respect to the ADA settlement, the American with Disabilities Act, and the Olmstead Act, as you read here?

MS. HERNANDEZ: Objection.

You can answer?

A Again, the American Disabilities Act settlement is adult centric, but there is a small covered live overlap for foster care, in that young people who sign themselves back into care can continue to be covered -- at this point in time it was through age 20, but for foster care, in accordance with the ACA, the Affordable Care Act, extended to 26, trying to be sure they were recognizing for adults that we needed to be contemplating early intervention in communities ahead of institutional settings.

Q Do you have that same expectation with respect to children's behavioral health services broadly?

MS. HERNANDEZ: Objection.

You can answer.

A Of course that is subjective, but, yes, that is my daily hope.

Q Let's scroll down to Page 9. I have a

question about a term you used toward the bottom of the page, "geographical access standards."

Do you see that?

The second to the bottom paragraph.

A I do.

Q What are you referring to?

A So this is a document recommending what the hopes are for the vendor, and so what we are saying here is that, that the outcome would be that they have geo access standards related to the basic services package and then further promoting access to specialists, or in this case like specialized service access, in that second or third sentence.

Q And do you know whether in fact any vendor in connection with this proposal has implemented geographic access standards per your recommendation?

MS. HERNANDEZ: Objection.

You can answer.

A I think the DCH would have to answer that. I've not seen any geo access measures from the CMOs.

Q And does DBHDD use geographic access standards?

A We do not have those in place either.

Q Let's scroll down --

A That I'm aware of.

Q Thank you.

MS. HERNANDEZ: Patrick, how much longer with this exhibit?

MR. HOLKINS: Five minutes. I'm sorry I know I've gone on a bit long. Just five more minutes and we'll take a break.

A I do want to harken back to, though, again, we are in a unique position related to coverage because of the Community Service Boards in that we have statewide -- we know we are covering all counties through the Community Service Boards or through other Tier I vendors that we have that statewide access

So we, we in a lot of ways are able to operate based on the knowledge that we have that coverage and that we are contracting for that coverage separate from geo access standards that would be typical to a provider network management model that would come from an insurance company.

So I think that's why we are able to operate in some manner slightly differently, because we are the administrator of a safety net via contract through the Community Service Boards and their role is set forth in law.

Q So is your point that there is no added

value to having geographic access standards since you have the safety net --

A No, no. There would be. I'm not saying that at all. All I'm saying is that we are able to operate with some functional confidence that we have at least statewide coverage everywhere because of our contractual relationships and the role of the Community Service Boards as a safety net, as identified in law.

Q Are you confident that you have statewide coverage for IC3 even though you have two providers, which by your own admission each are serving 150 plus counties?

A So we --

MS. HERNANDEZ: Objection.

You can answer.

A So there has been review of the provider use, the utilization trends for access related to IC3. It was a result of that service review and looking at that that then we embarked on adding two new providers to the network.

So at a point in time we assessed -- again, we went live 2017. 2018, 2019-ish we looked at utilization trends and then made some decisions in the past two years to expand that network

capacity in order to address that.

Q You're expanding the capacity because you felt that the existing capacity was insufficient?

A It --

MS. HERNANDEZ: Objection.

You can answer.

A Uh-hum. (Affirmative.)

Q Okay. So skipping down, on Page 12, you write: "Resistant to treatment is often a phrase used when" -- excuse me. Let me start again.

"'Resistant to treatment' is often a phrase used which should not describe a youth/family, but is traditionally used when a system has not found the engagement strategies necessary to begin a course of treatment towards recovery."

Was that statement accurate when you drafted it?

MS. HERNANDEZ: Objection.

You can answer it.

A Yes. And it is still an industry challenge, that many people use the phrase 'resistant to treatment' to describe a family or young person when the system has not been flexible enough to figure out the best pathway to serve a

child and family.

So by putting that statement in here, it is asking the DCH to ask its proposing vendor to not settle with those types of statements and to push the envelope to be more responsive in creatively finding the pathway to best serve the family and young person.

Q Last question and then we'll stop.

Let's scroll down Page 14, which describes ESPDT service. Do you see where I am?

A I do.

Q Let me first ask you whether the list on Page 14 and 15 of the essential basic benefits under EPSDT is complete?

I'll give you control. You can actually jump in, if you like.

A Thank you.

(Witness reviews exhibit.)

A So let me just say there is nothing about EPSDT where a list for me would indicate complete.

Q Could you explain why?

A EPSDT, in my read and interpretation, really defines that any medically necessary service could potentially be a match for a young person served, and there could be a new emerging best

practice, a publication being published today that we don't know about.

So any law -- any list, pardon me.

Any list that would purport to be "the list" is not complete, and that's why this language, the precursor language says, that the essential basic benefit shall include.

So it was meant to be a signal that in general these are kind of what is on most lists nationally for a public sector behavioral health benefit, but indeed at no point do I ever consider an EPSDT list to be complete.

Q Thank you for the helpful clarification.

School-based behavioral health services are identified on this list, correct?

A Yes.

Q Would they still be identified on this list today?

A I would have them there, yes.

Q How would you define school-based behavioral health services as used in this document?

A I will harken back to the response this morning, that school-based behavioral health services is a large umbrella, and there could be a myriad of services provided underneath that

umbrella.

So when I look above, medication management could be provided in the school. Brief intervention could be provided in the school. Psychiatric treatment could be provided in the school.

So there's not a box that is prohibitive. It is really about how the particular school setting can kind of tolerate in terms of space, how they could bring to bear the right practitioners in that right space to do services, but for me school-based mental health, behavioral health services is a large umbrella under which several sub-billable items can fit.

MR. HOLKINS: Okay. Let's go ahead and take a break for 20 minutes.

Thank you, everyone, for your patience.

THE VIDEOGRAPHER: Off the record at 3:43.

(A recess was taken.)

We're back after recess.

Back on the record at 3:57.

BY MR. HOLKINS:

Q Just one follow-up question from our previous line.

We were talking about EPSDT benefits,

correct?

A Correct.

Q Is DCH the entity in the state that's charged with implementing EPSDT services?

A Yes. EPSDT is a Medicaid regulation, and as such the Medicaid authority is responsible for them.

Q Do you have any responsibilities with respect to the implementation of EPSDT benefits?

A Again, as partner on the category of service 440, the list of service you saw for individuals who would meet the Medicaid aged, blind, disabled eligibility type, we would partner with the DCH in any needs specific to those young people in terms of implementation.

Q Let's shift gears. I want to ask you some questions about GNETS.

Let me first ask you when you became aware of GNETS?

A Under a different name, almost as soon as I came to work for the State, late '90s. Back when it was maybe the title Psycho Educational Programs.

Old school. I've been around for long.

Q So I'm looking at your resume. I believe you started at DBHDD in 1997; is that correct?

A Correct.
Q That's when you first became aware of GNETS?
A Yeah. On or about that time.
MS. COHEN: 24 years ago.
THE WITNESS: Longer.
Q What is your understanding of what GNETS -- I'm sorry.
A She said about -- she said about 24 years ago and I said longer.
Q What is your understanding of the GNETS program?
A So, again, as I articulated this morning, that they are specialized educational facilities where young people with some particular -- particularly challenging needs in terms of meeting their educational goals, where those particular educational goals can be more targeted and more focused.
So that's about the extent of what I know of the GNETS programs.
Q What informs their understanding?
A Basically being on IDT, just having heard a presentation or two over the course of my years with the IDT, and I was a family member, so I've

been around since it began.

However, I have not ever visited a GNETS program, or I've never read any specific policy for that. So my in-depth knowledge is limited.

Q Do you know what the target population is for the GNETS program?

A Not in any more detail than I just articulated, which is individuals who are unable to achieve some of their educational goals because of a myriad of factors and need some targeted and specialized supports in order to achieve those goals.

Q Do you have any duties currently with respect to the GNETS program?

A No.

Q Have you ever had duties with respect to the GNETS program since joining DBHDD in 1997?

A No. And I think it's 1995.

I just wanted to say that for the record. I know you have my resume as part of the record, but '95.

Q That title may not be reflected on the resume but I have no reason to question you, so thank you for your clarification.

I want to show you --

MS. COHEN: This is it, Patrick. Sorry.

(Discussion ensued off the record.)

BY MR. HOLKINS:

Q Are you a part of DBHDD's enterprise leadership?

A Yes-ish. There is -- we talk about enterprise functioning as being a support of the Division's line of business, and so am I part of that leadership? Yes.

We don't call it that per se, so I'm just -- I'm struggling to answer it because we don't necessarily call it that.

Q Have you heard the term "DBHDD enterprise leadership" before?

A We talk about enterprise functionality. That there is a enterprise functionality that supports the lines of business, and I am an office director in that. So I am part of like the management team that is inclusive of a lot of this work, but we just talk about enterprise functionality as being like supports to the main lines of business.

So, again, harkening back to -- so I'm a counterpart like to Dante, but he oversees a line of service delivery to young people. It has to be paid

for. The paid for part is an enterprise functioning.

It has to be captured in IT systems. So John Quesenberry is a counterpart of mine doing IT functionality.

I help build Medicaid policy and practice around that children's delivery line. So enterprise is how we talk about all of the buttresses that support the actual building, which is the service lines.

So that's my best way of describing that.

Q Thank you.

I'd like to show you a document. This will be Exhibit 146. Give me one second.

(WHEREUPON, Plaintiff's Exhibit-146 was marked for identification.)

BY MR. HOLKINS:

Q I've just shared Exhibit 146.

For the record, this document is Bates-stamped GA04225637. It includes an attachment that will be a part of the same exhibit.

This appears to be an email from you dated January 3rd, 2018, to Melissa Sperbeck, with the subject "Re: 1115 brainstorming Values/Drivers."

Is that correct?

A Uh-hum. (Affirmative.)
Q Yes?
A Yes.
Q Thank you.
And in this email you indicate that you are attaching a document, and it appears to be a document with 1115 brainstorming considerations.
Is that accurate?
A Correct.
Q First, was DBHDD at this time considering applying for 1115 Medicaid waiver?
A So the Department of Community Health had indicated some interest in considering an 1115 at the time, and so we were beginning some brainstorming considerations to inform some dialogue related to that if it were to come to pass.
Q So let's shift now to the attachment. Give me one second.
This is the second part of Exhibit 146. It's Bates-stamped GA04225638.
I will give you a moment to review the document. Give me a second and I will give you control.
(Witness reviews exhibit.)
A Okay. The one comment that I want to make

is that it looks like this was printed and scanned, so the color coding is not available.

So I recognize there is a color spectrum cited in here and I can't --

Q I understand your point.

A -- see that.

So that may impact kind of how adequately I'm able to address your questions, but I just -- having made that comment, we can continue.

Q Let's just briefly address that.

So I recognize this is -- it's not a document in color. This is how it was produced to us by the State.

A Got it.

Q This is the only version we have. However, there are still -- there is a gradient of shading which you can discern on the document. Is that accurate?

And you still have control.

A Thank you. Let me just.

Yeah, I think it's relatively clear. It's just a little bit more difficult in the absence of the coloration, but I think it's pretty understandable.

Q And just to complete this discussion, the

more darkly shade entries in this chart, which lists potential target populations for an 1115 demonstration waiver, the more darkly shaded entries are less favorable. Is that accurate?

A Yes. I just want to be clear that in -- related to an 1115, favorable does not always mean preferred. An 1115 requires something called cost neutrality, and so what I want to be clear for in terms of finalizing this for the record is that less favorable in many cases also is related to criteria based on how much savings the State can demonstrate through an 1115. Because if you fail cost neutrality, there's penalties to the State.

So there's some dynamics with that, that I just want to be sure, that favorable is not, oh, this isn't a priority for us philosophically. Favorable related to an 1115 also is about can the State have the type of outcome that is mandated as a fundamental element of that Medicaid pathway.

Q Understood. So let's first, before we jump to that, on Page 1 -- first of all, you drafted this document, correct?

A I did. Uh-hum.

Q On Page 1 you list some desired outcomes. Among the desired outcomes you identify are

decreased out-of-home/out-of-community services. Correct?

A Correct.

Q Why did you chose that as a desired outcome?

A Because it is the mission of our agency to have early intervention and prevention long before somebody would need to be removed from home or receive services in an institution or the like.

So our -- one of our founding drivers and almost all decisions we make is to be sure that we are serving as early as we possibly can in terms of service design to mitigate the need for a young person to be removed from family, an adult to be removed from community, for anybody to have to receive a service in a more restrictive place versus in their communities, in their place of work, in their homes.

So that is kind of a driving philosophy of our departments.

Q Skipping down to the section we were discussing previously, which is titled, "Potential Target Populations," I want to focus on the first entry, which is Child and Adolescent SED, and in parenthesis SOC.

SED, as we discussed earlier, means serious emotional disturbances?

A Yes.

Q SOC, means System of Care?

A Correct.

Q There are a number of opportunities identified for this target population. One is System of Care/Cross Agency Opportunities, correct?

A Correct.

Q And another is GNETS Review, correct?

A Correct.

Q What did you mean by GNETS Review?

A So at this point in time, again looking at the date on this document, we were aware of that there was inquiry occurring to the State related to GNETS and were trying to consider all of the factors in play to be sure we could do early services for young people, again long before they would need any kind of removal from community or from home.

Q And by removal, you mean placement in GNETS?

A Placement anywhere external. And let me just be clear.

Placement is a construct of like needing somewhere to live, but there are also out-of-home

treatment alternatives, which we also put less value on because, again, from the removal from communities, removal from home, removal from parents.

So, like, for instance, a PRTF is a treatment removal. It's not a placement. It's not we're saying the kid needs to live here, we're just saying the youth needs to go for treatment and it is externally removed.

So I wanted to caveat the term "placement."

Q That's a very helpful clarification.

So as you just described, would a child being enrolled in GNETS facility outside of their home community qualify as external treatment?

A Because I don't know the reason for the child being removed -- again, like I don't know the parameters of even how a young person necessarily moves to GNETS. Is that about their educational goals or their treatment goals? Then -- and I've not seen that eligibility criteria. I just don't want to presume that they are being removed for treatment versus being removed for their educational goals.

So I've not seen the admission or

placement or any of that criteria. I don't think ever.

So while I hear and I've articulated my perspective on the gist of what it is, I don't want to say that they're being removed from the community for treatment purposes without having seen that criteria.

Q Understood. And so whether it's for educational reasons or for treatment reasons, it still is a removal from the community, correct?

MS. HERNANDEZ: Object.

You can answer.

A If I'm thinking about like physical location, yes, it is a removal from their community, and therefore from our value perspective that would be a least desirable pathway.

Q What came to pass with this recommendation of this specific target population for an 1115 demonstration?

A So, in general, all of these target populations, the conversations ended as Medicaid began having some kind of alternative conversations about where they might want to go next. So none of these dialogues continued.

But specifically to this target

population, you see in the third column the risks are noted in that the cost for these young people are managed through a capitated payment arrangement. So the demonstrable evidence of how much we saved as a state was not really going to be a potential yield in this dialogue for DBHDD's perspective because it has to be cost savings related to Federal Medicaid.

So it could have been a cost for the young people for the State of Georgia through the Department of Education, but 1115 was not really the mechanism that DBHDD needed or wanted to then consider because of some of these dynamics.

So, again, we took some of this conversation to the DCH and ultimately this -- the whole concept of an 1115 was tabled.

Q Okay. So no 1115 demonstration waiver application resulted from this discussion?

A No.

Q And the principal reason for this particular target population, including review of GNETS students, not being viable is the cost neutrality concern that you just raised?

A Yes.

MS. HERNANDEZ: Object.

You can answer.

THE WITNESS: Sorry. Too fast.

Q And since this time, have you discussed any other waiver opportunities that would be targeting students enrolled in GNETS?

A No.

Q Let's set this aside and skip to the next document.

MR. HOLKINS: I've just produced what I'm introducing as Exhibit 147.

(WHEREUPON, Plaintiff's Exhibit-147 was marked for identification.)

BY MR. HOLKINS:

Q For the record, this is GA04234690. It's an email chain from April 2018. It includes emails to and from you.

I'll give you a chance to review the thread.

MS. COHEN: Did you say 90?

MR. HOLKINS: It's GA04234690.

MS. COHEN: Thank you.

BY MR. HOLKINS:

Q You have control.

(Witness reviews exhibit.)

A Okay.

Q So the title of the email is "Re:

Appointment Request: Update on GNETS." Correct?

A Correct.

Q So let's go back to the first email in the chain, which is dated January 12th, 2018, and this is from you to Amy Howell. Is that correct?

A Correct.

Q Who is Amy Howell?

A She was our chief legal officer at the time.

Q Okay.

MR. HOLKINS: Do we have any concerns?

MS. PATEL: Yes.

MR. HOLKINS: Okay.

MS. PATEL: Can you give us a second?

MR. HOLKINS: Yes.

You guys want to discuss?

(Discussion ensued off the record.)

THE VIDEOGRAPHER: Off record at 4:22.

(A recess was taken.)

THE VIDEOGRAPHER: Back on record at 4:29.

BY MR. HOLKINS:

Q So, Ms. Tiegreen, I was directing you to the first email in this chain, and, for the record, we're talking about Exhibit 147 Bates-stamped at GA04234690.

I want to ask you about your email on January 12, 2018, where you write: "Melissa and I have conferred with Commissioner on this subject and she recommended a brief appointment with myself and you to receive an update on the status on the following," and then you included a link. Is that correct?

A Correct.

Q That link appears to be to a summary of a complaint filed in another matter concerning the GNETS program; is that correct?

A Correct.

Q And you reference the Commissioner in your email. Is that the Commissioner of DBHDD?

A Of DBHDD, yes.

Q Was that Judy Fitzgerald at the time?

A I think so. It's right on the cusp.

I'm pretty sure it's Commissioner Fitzgerald at the time.

Q You write that Commissioner Fitzgerald, or the Commissioner of DBHDD at the time, recommended a brief appointment.

Was this appointment with respect to GNETS?

A Yes. It was -- we had -- I had received

this actually in my inbox, being on Bazelon's LISTSERV, and had been like, um, I sit on IDT and might need some information about this.

So that's kind of the genesis of where this had come from. So Melissa and I had a meeting with Commissioner, not specific to GNETS, but just in general, and I was like what -- what's going on with this?

And so she suggested a conversation with Amy Howell at that point in time.

Q What was the -- what was intended to be the subject of the conversation?

A So just to get a status update on what was going on with the case, because, again, I allude to further up that Dante and I sit in meetings with some of these folks and just wanted to be briefed.

Q So you're referring to another email in the chain dated April 18, 2018, where you write that: "Dante and I are in a lot on dialogues with DOE, DCH and others who are involved and feel like we need to get an update on the status."

A Right. Again, with IDT we are in a lot of meetings collaborative with other organizations. And so I just did not want to be taken off guard by anything going on with the suits, and that was the

first time I had seen the update on that, was through Bazelon.

So that was the nature of the request.

Q And when you wrote that "DOE, DCH, and others who are involved," are you talking about involved in the GNETS program? What are you referring to?

A So I presumed from reading the statement of Bazelon that DOE and DCH would both be involved in that process, and we sat in meetings with them all the time on just child centered issues. So just wanting to be sure that we were informed on whatever the status was, so that we could, again, not be taken aback by anything that came up specific to that in those just generalist collaborative meetings.

Q And did you in fact have an appointment as a result of this email chain?

A I don't think we did. I don't think we did.

Q Did you ever receive an update around this time regarding the status of the GNETS litigation?

A I don't think I did. I mean I think we were just very busy, and Amy left service -- I'm not even sure when. So I'm not sure if that was related

to that or not, but, yeah.

Q Why did you think it was important for you not to be taken aback? I think were your words.

A Correct.

MS. HERNANDEZ: Objection.

You can answer.

A So what we did not want to be -- what I did not want to be in a position of and the reason why I brought this up to the specific group is we do a lot of cross-agency coordination and collaboration with our sister agencies, and if there was anything going on in particular that was related to our agency's involvement in this or not, I just felt like it was better to know about it than not to know about it.

And so -- but there are -- we are a large department and there are a lot of complex issues that we navigate all the time, and so if I had not gotten an update on it, I would have been just like, Amy's busy and we'll get to it or I'll learn about it later. But I was never in anything specific subsequent meetings with DOA -- DOE or DCH related to GNETS.

Q And do you feel now it would be valuable for you to have more information about what's

happening with respect to the GNETS program?

MS. HERNANDEZ: Object.

You can answer.

A Hard to know. I mean that's just subjective. I -- again, most youth in Georgia are covered by DCH, and so in that case we're always kind of navigating about what is really our knowledge, authority and purview.

And so it might be helpful, but, again, I saw the interrogatories -- began to see the interrogatories soon after this, and so began to know that my voice was going to be asked for and affirmed and that we would be at least responding to the questions on behalf of the inquiries.

And so, really, there's sometimes so much water coming through the fire hose that not getting the update also did not make me lose sleep. Like I wanted to be involved but I also have great trust in our teams and our representatives who are working on this.

Q Are you --

A So just to them.

Q Understood.

Are you aware of whether there are any DBHDD beneficiaries currently enrolled in GNETS

programs?

A Not specifically. I might guess that there would be some youth in GNETS programs that would meet the age, blind, disabled qualifications for Medicaid, but I've not looked at any data specific to that.

Q Have you reviewed or performed any assessments of the quality of services provided to DBHDD beneficiaries who are enrolled in GNETS?

A No.

Q So let's put this aside. I've got another document to show you, which will be 148.

(WHEREUPON, Plaintiff's-Exhibit-148 was marked for identification.)

BY MR. HOLKINS:

Q I've just produced what I'm introducing as Exhibit 148. You'll note at the bottom of the Bates number for this document is --

MS. COHEN: I'm sorry, did you mark an exhibit?

MR. HOLKINS: Yes.

MS. COHEN: What number?

MR. HOLKINS: This is 148.

MS. COHEN: And the Bates number is?

MR. HOLKINS: GA04324126.

MS. COHEN: Thank you.

MR. HOLKINS: Okay.

BY MR. HOLKINS:

Q This appears to be an email from you to Melissa Sperbeck, dated 10/28/2020, correct?

A Correct.

Q And there are -- there's a list of things in the email. Among them is GNETS, BHA, Telehealth, a number of others.

Could you describe what this email is?

A Can you scan all the way down or can I take control?

Q I'll give you control.

(Witness reviews exhibit.)

A Candidly, it is hard to figure it out without the context. So I don't know if -- so Melissa, as my supervisor, and I would often be going back and forth about -- it looks like almost it would be agenda items of outstanding content that would be pertinent for just in general behavioral health conversation.

So I'm not sure if she was going into a meeting where she was asking about kind of what opportunities were for some collaboration between us and the Department of Community Health, but clearly

it is all lines of Medicaid service, and these are kind of what I would be considering in 2020 what would have been like open items that would be for potential updates.

So that's my best guess, having no other contextual frame here. Because even some of these things were like point-in-time items. So like the evaluation management codes, E/M Codes, pre and post-time being allowed, like that was a federal change in the way that coding was done, and it doesn't comport with how we have rates set, like in our Medicaid State Plan. So it would have been like, hey, DCH, do you -- are you aware of this? Do we need to share this with you?

So it looks almost like it's kind of things that are in the ether related to behavioral health where she might have been trying to get a high-level expectation or understanding or sense of what were kind of topic points at the time that were kind of in the frame for behavioral health.

Q What specific issues with respect to GNETS were in the frame at the time of this email?

A It would have been really just that we were aware of the interrogatories and just being sure that there was communication between the two

departments, that we were responding and anticipating that they were also responding, because, again, we've not done any collaborative planning with the DCH on anything related to GNETS.

So -- again, like QRTP, like that is something that DFCS just had an idea for. So, again, when I'm talking about, these feel like things that were kind of in the ether.

Like I know QRTP was something that was on the natural slate for foster care children, but it wasn't like we were necessarily adopting it, we weren't moving forward with it. It was just a point of reference to be like, hey, we hear Child Welfare talking about this. Are you thinking about this? Are you doing anything? Are you reading anything about this?

So that's kind of the way I read this list. Because some of these things are just really quite big and they are conceptual, and so they weren't necessarily like things we were working on. They were like elements of, hey, are we both aware of this? Are we both kind of tracking on this?

Again, like the DOAS Tele Procurement, the Department of Administrative Services for Georgia was releasing a telemedicine procurement. We

weren't in charge. DCH wasn't in charge. But, hey, DCH, do you know about this, is kind of the spirit at which I read these subject lines.

Q Okay. You state at the top line, "EPSDT and DCH - get with BF."

What is BF?

A I was trying to think if those were somebody's initials I can think of right away, but I can't think of -- I can't -- get with BF. I'm not sure who BF is, actually.

Q That's okay.

What do Penetration Reports refer?

A To penetration reports are cost accounting principle reports. So we have a cost accountant -- cost accounting plan with federal CMS, which talks about, of the people DBHDD serves, what penetration are Medicaid eligible beneficiaries, and then how we can use those reports to do official administrative claiming for the department.

So we were in the process of working with the ASO to reconstruct those penetration reports. So, again, it's like one of those things where it was like, hey, DCH, we're working on reconstruction of these reports. You know, stand by and we'll get more information to you.

Again, that one reinforces the type of nature of what that list looks like to me.

Q Stepping back from that exhibit, which we've set aside, in connection with GNETS and in your official capacity at DBHDD, do you coordinate --

MR. HOLKINS: Let me start again.

Q In connection with GNETS in your official capacity at DBHDD, have you coordinated directly with Nakeba Rahming?

A I don't even know who that person is, no.

Q Do you know who Debbie Gay is?

A Yes, I do know who Debbie Gay is.

Q Have you coordinated with her with respect to the GNETS program?

A No. She's just participated in IDT, is the only way I know her.

Q Do you know -- sorry. Go ahead.

Do you know who Vickie Cleveland is?

A No.

Q Do you recognize the name Zelphine Smith-Dixon?

A It sounds familiar but it's nobody I've worked with. She might have been copied on something once or twice, but I -- it's an unusual

enough name where I think I've seen it, but I've not been in any kind of coordinating meetings or conversations that I recall.

Q Are you familiar with Clara Keith?

A No.

Q Have you coordinated with any directors for individual GNETS programs?

A No.

Q Have you ever visited a GNETS facility?

A No.

Q Have you ever provided training or technical assistance to GNETS staff?

A No.

Q You mentioned earlier doing some -- leading some trainings that are -- for instance, on the 988 system?

A Yes.

Q That are broadly available in the State, correct?

A Correct.

Q Do you know whether any GNETS program staff participated in those trainings?

A No.

MS. HERNANDEZ: Objection.

You can answer.

A They've not ever been a target. So if it was -- if I was like presenting something that was like made available to the general public, they could have participated, but they wouldn't have ever been a target on our invitation list.

Q Their participation would have just been incidental?

A Incidental, yes.

Q Do you review any information regularly with respect to the GNETS program?

A No.

Q And that includes information with respect to utilization of behavioral health services by students in GNETS?

A Correct. I've never -- our utilization information is not at any of that kind of granular level to have identified the youth as being in GNETS or not in GNETS.

Q Have you seen any data or information specifically for DBHDD beneficiaries with respect to the length of their placement in the GNETS program?

A No.

Q Have you seen any data specific to the DBHDD beneficiary group with respect to referrals from school districts to the GNETS program?

A No.

Q Have you seen any data or documents showing referrals to specific services like IC3 for students enrolled in GNETS?

A No.

Q Have you ever spoken with Dante McKay regarding GNETS?

A Yes.

Q When is the last time you spoke with Dante McKay about GNETS?

A Months ago. And I can't even remember a specific, but I just know enough to know that -- like, for instance, in this email where I was like, hey, what's -- should we get some information about GNETS?

But I've not had any regular dialogue with him on GNETS at all.

So it would -- there's been just a tremendous amount of time that has passed but I can't pinpoint how long that would have been.

Q So as best as you recall, the subject of that conversation with Dante regarding GNETS was to potentially seek out more information?

A To be like, hey, what's up? Or have you heard anything lately about the process?

We were mutually copied on some of the interrogatories and so I do know that we had transactional visibility in our responses on that, and so that's really the last specific interchanges I remember with him.

Q I'd like to show you another document. This will be Exhibit 149. If you give me a second, I will tell you the Bates-stamp.

(WHEREUPON, Plaintiff's-Exhibit-149 was marked for identification.)

BY MR. HOLKINS:

Q So I just produced Exhibit 149. For the record, this is GA04205173.

I'll give you control in a second, but I'll note for the record this is an email from you to Marcey Alter, dated May 15, 2017. Correct?

A Correct.

Q I will give you a second to review the document.

You have control.

A Thank you.

(Witness reviews exhibit.)

A Okay.

Q So I want to scroll down to the first email in the chain, which is dated May 12, 2017.

This is from you to Marcey Alter and Linda Wiant, and cc's Melissa Carter. Correct? Who is --

A I want to just clarify, when you asked me about Melissa Carter earlier, is it this Melissa Carter you were asking? You said Melissa D. Carter, so I did not presume that this is a link.

Can, can you clarify for me?

Q Yes. I was referring to this one.

A Okay. So this is a staff person of the DCH. There is another Melissa Carter somewhere in children's advocacy, I think. So in my earlier response --

Q Yeah. I think that's fair.

I think that question was within the context of the Georgia Ombudsperson for Children. So that could be a different Melissa Carter.

A Thank you.

Q Yes.

A This Melissa Carter worked for the Department of Community Health and was a staff who was appointed by the Department of Community Health at the time to help coordinate some of the work within DCH specific to the autism benefit roll-out.

So when I saw this name, I wanted to be sure we didn't have any confusion earlier. So thank

you for clarifying.

This is a different Melissa Carter. She is no longer with the Department of Community Health.

Q Thank you. And Linda Wiant, she's identified here I believe as a DCH employee?

A She was the chief Medicaid director who has left the organization as well and was replaced by Lynette Rhoads.

Q Thank you.

You write in this email dated May 12, 2017: "At the Carter Center today, there was a reference to Autism related to the GNETS settlement and needing services in schools. While we can say there will be allowances for this, we may need to build something specific into our infrastructure ask on developing this."

Correct?

A Correct.

Q Could you expand on this statement, "we may need to build something specific into our infrastructure ask"?

A So at this point in time was when we were doing the budget and design for the autism benefit rollout. So if you will recall from my earlier

statement, the Governor's Office charged the three agencies, DPH, DCH, and DBHDD, to coordinate what would be the design model for the autism benefit.

And so having heard someone on the stage, and knowing the date, this would have been the Carter Center Mental Health Day, where panelists get on the stage and just say what they wish and desire in the realm of behavioral health policy.

Having been an audience member, I heard it and said, I know there's going to be allowances for providing services in schools. We had already designed that. So while I can say there will be allowances for this, I am saying to Medicaid, in their projection on their infrastructure design and their ask related to the finances for this program that they be specific in being sure to have that as part of that budget ask related to that specific benefit design that they administer, that we don't. But, again, we were serving as Subject Matter Experts and collaborative partners on the design for that initial implementation.

Q So the thinking here is that DCH may need to seek additional appropriations to fund the autism benefit in GNETS schools?

A It wasn't additional at the time. It was

developmental. So it was the first budget ask for their outpatient benefit design. So it was -- I knew we were in the process of building that into that moment, and so I am just sending them an extra tag, be sure you're mindful of this, DCH, as you're thinking about this design.

Q Again, I want to return to my question.

You're asking them to be mindful of financing this benefit specifically for the GNETS population, correct?

A I am hearing the folks on the stage say that -- they were speaking to autism in the settlement. I'm aware that we're designing an autism benefit. So the folks on the stage say we need more autism services in schools, and I am saying related to the design that is in the middle of being built -- I know we've already been designing this to be available -- to have the allowance to be provided in the school but let's just remember that you might want to plan in your budget, be sure that there is budget capacity to really promote that.

Q Okay.

A So I wasn't saying design this to target GNETS. I'm hearing GNETS speakers on the stage

talking about the GNETS settlement and they mention autism needing the services in schools. I am understanding that -- I'm sitting over here designing some autism work with DCH and saying, hum, this makes me think we've got to be sure and be mindful that we are developing this product in a way that is responsive to the voices I'm hearing from the panel on the stage.

Q What GNETS settlement are you referring to?

A Whatever the one was that they were talking about on the stage. I can't -- I haven't kept up with any of the detail.

I know people talk about GNETS I and GNETS II. I know what interrogatories I replied to, but I'm not tracking that granularity. Whatever was being presented that day from the Carter Center. Whoever made a reference to the GNETS settlement, that would be the source.

I don't recall who was sitting on the panel that day because there's hour after hour. There's different panels talking on a Mental Health Day at the Carter Center.

Q Why did you reach out to DCH about this?

A Because DCH was crafting -- and they were

the ultimate holder of the autism benefit. So, again, back to the conversation from this morning, three agencies were charged in terms of considering implementation pathways for service. DCH was going to be the primary holder of designer governance structure, monitoring and payor for the autism outpatient benefit. So any of those benefits that would happen in an outpatient setting were going to be governed and directed by the DCH.

And they continued to be governed and directed by the DCH.

Q Have you made any other recommendations based on information about the GNETS case?

A No.

Q So let's shift gears. I'm going to stop sharing this document.

We've talked a bit today about IDT which I believe is the Interagency Directors Team, correct?

A Correct.

Q I think you've described yourself as a founding member of IDT. Is that accurate?

A That's accurate.

Q So you've been involved with this entity since its formation?

A Yes.

Q And you're still involved today?
A I am.
Q And you sit on the subcommittee for IDT, correct?
A I do.
Q What is the name of that subcommittee again?
A Busted on a couple, but I chair what's called the Behavioral Health Financial Mapping Work Group. And then I also sit on a committee for parent and youth peer support development.
Q And the IDT committee works on implementing Georgia's System of Care plan.
A Yes.
Q Is that accurate?
A Correct.
Q I'd like to show you some documents related to the System of Care. I'd like to show you what I'm about to introduce as Exhibit 150.
I'll give it a document number in a second.
(WHEREUPON, Plaintiff's Exhibit-150 was marked for identification.)
BY MR. HOLKINS:
Q This is GA04312715. It's Part 1 of

Exhibit 150, which is an email that includes an attachment, which will be Part 2.

I'll note for the record this is an email sent from Dante McKay, dated July 21, 2020, to a long list of recipients, which I believe includes you.

I'll give you a second to review the email. Let me share it with you. I'll give you control.

You have it now.

A Thank you.

(Witness reviews exhibit.)

A Okay.

Q I will take control back.

So if I'm not mistaken, with this email Dante McKay is forwarding the final draft of the State's System of Care plan for 2020. Is that correct?

A Uh-hum. That's correct. And he's forwarding it to internal DBHDD members.

So I would have received it as a result of being on IDT. He is sending it to DBHDD only staff here to give them the FYI, but I am of course copied again.

Q Understood. So you would have received

this as a member of IDT in addition to being a member of DBHDD?

A Yes. And informed it, the design creation of it.

So the IDT members actually craft the state plan.

Q Understood. Let's pull up the final draft that's attached to this email.

For the record, this is GA04312718, and it is the attachment to the email we just discussed and is Part 2 of Exhibit 150.

There's no need for you to review this at length. I just want to confirm that this is the final draft of Georgia's System of Care state plan for 2020?

A As Dante references in the email, this was the version that went to the Behavioral Health Coordinating Council for approval.

So I do not recollect there having been made any changes to it from that group as the final endorser. So I presume this is substantially the final.

Q Okay, thank you.

The final document, which I understand would be approved by the Behavioral Health

Coordinating Committee, is that publicly available?

A Yes. It's on the IDT website now. And I think it's is also on the DBHDD website as well.

Q So let's put this aside.

I want to show you now another document from the same time period relating to the System of Care. We'll start with an email.

This is Part 1 of what I'd like to mark as Exhibit 151.

(WHEREUPON, Plaintiff's Exhibit-151 was marked for identification.)

BY MR. HOLKINS:

Q The Bates-stamp is GA04303079.

This is an email from somebody named Breyanna Marshay Mikel, who appears to be an employee of Georgia State University.

Is that correct?

A I think -- if so, she may have been an admin assistant. Not anybody I worked with with regularity. But of course the tag looks like it would be -- someone from COE.

Q You received this email, correct?

A I did.

Q The subject is "System of Care State Plan - Access Session." Correct?

A Correct.
Q It's dated 5/13/2020.
MS. COHEN: This is still 150, right?
MR. HOLKINS: We are 151.
MS. COHEN: 151. Sorry. What is the Bates number?
MR. HOLKINS: GA043 -- I'm sorry. GA04303079.
MS. COHEN: Thank you.
BY MR. HOLKINS:
Q So the main purpose of showing you this is to direct you to an attachment. I'll pull that up.
This is the first attachment to the email we just described as part of Exhibit 151. The Bates number is GA04303081.
I'll give you a second to review this document. Let me know when you finish.
You have control.
A Thank you.
(Witness reviews exhibit.)
Q What is this document?
A So the state plan has, for the System of Care, has different header types, and so this one is specific to access, and then there were sub-strategies for ways to consider, and then

potentially promote access.

So, for instance, 1.1 is the behavioral health services mapping that I've been referencing throughout the course of the day.

Q Is it fair to say this is a progress tracking document?

MS. HERNANDEZ: Object.

You can answer.

A This was an initial step towards actualizing the plan. So I wouldn't call this a progress document because this was really from the time where we were wrapping up the plan draft and taking it to BHCC that summer.

This was a representation of really kind of what is happening with that work, and then -- can I ask a clarifying question?

This was dated which -- this is dated what date?

Q The title of the document reflects updates from 2017 to 2020.

A So I think it is then representative -- because the plan that you were showing a moment ago was adopted in 2020. This is a document attached, which is an update representing 2017 through 2020. So then for me this -- I'm just trying to

recalibrate a little bit now having seen this date timestamp at the top, that it's an update document.

It looks to be progress on the previous plan to establish some readiness for the next steps that needed to come from the plan that was being approved in 2020.

Q So this document is updating IDT's progress in implementing goals from previous versions of the System of Care program?

A Right. As a launch, it looks like from the email, as a launch for what we need to do next.

Q Okay.

A So then I want to just go back, having now seen the date at the top. The service mapping that is defined here, I was not chairing the leadership of that until 2020, which is the end period for this 2017 through 2020.

Q 1.2 identifies the following strategy increase behavioral health services in schools."

A Uh-hum. (Affirmative.)

Q That was the strategy under a prior version of the System of Care plan, correct?

A Yes.

Q The accomplishment identified is "School Based Mental Health services and support survey,"

correct?

A Yes.

Q Do you have any familiarity with that survey?

A We received a summation of that in IDT after the fact, but I was not involved in that sub-plan work group, so I don't have a lot of detail related to that.

Q Give me one second.

MR. HOLKINS: I've just shared another document which I'd like to introduce as Exhibit 152.

The Bates-stamp for this document is GA04307352.

(WHEREUPON, Plaintiff's Exhibit-152 was marked for identification.)

BY MR. HOLKINS:

Q Have you seen this document before, Ms. Tiegreen?

A I think I have. I could have been in the IDT meeting when it was presented, but I might not have been as well. So I can't recollect without checking calendars and the like.

Q So the date of this presentation, based on the first slide, is May 27, 2020. The title is

"System of Care State Plan: School Based Mental Health Year 3 Survey Results." Correct?

A Correct.

Q If we flip back to Exhibit 151, does this appear to be the school-based mental health and support survey that's referenced in this document?

A It does.

Q So you received a presentation, as best you can recall, as a member of IDT regarding this survey?

A I would have -- I would have received it. I just don't remember the results of it. So I may have -- may or may not have been in that particular meeting. So I'm just -- I'm not positive.

But as an IDT member, it would have been in my inbox for sure.

And I would just like to state this is right still in the throes of the first quarter of the PHE. So a lot of my standard work that I would have been involved with I was being diverted to rewrite and recraft and restructure a lot of our community-based policy for behavioral health.

So there were many standing meetings on my agenda and on my calendar that I actually was not present in. So -- or was partially present in. So

I am just going to be as clear as possible that this was a whirlwind time for us as administrators, and so there were no Saturdays or Sundays or evenings for several months at the onset of the pandemic.

So I'm looking at it and going, uh-hum, I see it. I know it would have been in my inbox but was it read? I can't say that it was.

Q So you've got control -- or I'll give you control of Exhibit 151, which is the updates to the System of Care plan implementation, 2017 to 2020?

A Sure. Yes.

Q Are there any updates with respect to services and supports provided to students enrolled in GNETS?

A Not that I'm aware of. And, again, I don't participate in any like subgroups or working groups on 1.2.

So I was heavily involved in 1.1 and 1.3 and 1.4, but not in as much as 1.2.

So, again, as a committee member there would been report-outs, but, again, I can't recall any specific detail about this because I'm not like a priority to this subject line. I'm an adjacent and adjunct to the subject line.

Q Have there been any report-outs to the

full IDT committee specifically relevant to the GNETS population?

A Not that I have seen or that I participated in. Could have been on a docket and I might not have been there, but, again, because I don't make every meeting, or I don't make all of every meeting.

Q Have you ever specifically raised the subject of access to behavioral health services for children enrolled in GNETS in an IDT meeting?

A No.

Q Can you recall a time when an employee of the Department of Community Health raised the issue of access to behavioral health services for students enrolled in GNETS in an IDT meeting?

A No.

Q Can you recall a time when an employee of the Georgia Department of Education raised the issue of access to the behavioral health services in GNETS schools in an IDT meeting?

A I can't remember a specific time, but certainly when Dr. McGiboney was an active member, that topic came up more than once, but again he's not been involved in IDT for many years.

Q Who are the current representatives for

the Georgia Department of Education on the Interagency Directors Team?

A Since Ashley Harris has left, I have not heard the voice very strong of anybody from DOE. And again, it's a large group that's grown. So there's about 60 members who participate, and so in a two-hour session me not hearing from a DOE representative would not be an unusual thing with that number of participants and with having a structured agenda but since Ashley Harris is no longer attending, I'm not sure who the DOE representative is.

We do have a liaison who works under Dante, who partners with the school system, and so she becomes most often my internal kind of point on school-related issues, but we've had no conversations about GNETS.

Q Is that internal liaison to the schools Layla Fitzgerald?

A Yes.

Q How often are you communicating with Layla Fitzgerald regarding services available to students in schools?

A Maybe once every couple of months. It's not within any regularity.

Q What's your understanding of Layla Fitzgerald's duties in her current role as liaison between DBHDD and the Georgia Department of Education?

MS. HERNANDEZ: Object.

You can answer.

A Okay. And again it's very generalist since I don't supervise her.

It's more relational and how she self-represents, but as being someone who's focused on kind of behavioral health services and how they might could be best provided to any kind of school age young person within the scope of what DBHDD manages.

Q Have you had any discussions with Layla Fitzgerald specifically about children enrolled in GNETS?

A No.

Q Have you had any -- to the best your understanding, is Layla Fitzgerald working on service access issues specifically with respect to the GNETS program?

A I'm am not aware specifically of that at all.

MR. HOLKINS: So I just want to note for

the record there is a third attachment -- excuse me, a second attachment to exhibit -- the email that's Exhibit 151, and this is, for the record, GA04303083.

This is Part 3 to Exhibit 151.

BY MR. HOLKINS:

Q I just want to acknowledge that this is the Georgia System of Care State Plan for 2017. Is that accurate?

Feel free to take some time to review the document.

A Thank you.

(Witness reviews exhibit.)

A Yes. To the best of my recollection and understanding, yes.

Q How often is the System of Care plan updated?

A The goal is for it to be I think every three years. Yeah, I think it's about three years. I don't have great assurance in my answer on that. I'm saying approximately.

Q So I believe based on your testimony that there was a System of Care plan that was released in 2020, correct?

A Yes.

Q And the previous version was released in 2017, and that's this version?

A Yes.

Q Would it be your expectation the next edition or update to the System of Care plan would be in 2023?

A Yes. I mean as far as my recollection. I can't remember the parameters that are set forth for it specifically or if there is any capability for it to be extended if some of the goals weren't substantially met. But I'm -- to the best of my knowledge, yes, about every three years.

Q Let's set aside the documents.

Broadly, what is the goal of Georgia's System of Care framework?

MS. HERNANDEZ: Objection.

You can answer.

A So, again, I'll harken back to the concept of System of Care we discussed earlier, which is about multiple partners who have an interest in not just from an agency perspective and scope of law, but external partners who are invested in children's behavioral health service, working collaboratively toward the goal of, of having the best public sector behavioral health response for kids for the state.

And so, again, understanding that we each have some stake in law, at least the State agency, some stake in law to support children in certain ways, in each of our scope of law we have overlapping children, and we're all kind of pointed to those children in terms of providing them the best supports to achieve their health, their education, their welfare.

And so if all of us are collectively in scope of law invested in that and we are then not coordinating and collaborating, then we really aren't using our resources the most efficiently and effectively on behalf of those youths.

So for me the system care is about being sure that we are not duplicating effort, that we are complementing one another's efforts, and then doing our best to be sure for the child and family that what they experience is a more coordinated and collaborative system through which that child is his or her best self.

Q Thank for you that explanation.

So I want to refer back to the testimony you just gave regarding the overarching purpose of the System of Care framework, which I believe you said is working collaboratively toward the goal of

having the best public sector behavioral health response for kids for the state.

Does that sound right?

A That's -- that is how it comes into my brain and out of my mouth. That is not a memorized statement for sure, but it is, it is my best operating definition of that.

Q Would services for children who are enrolled in GNETS fall within the scope of that, of that mandate?

MS. HERNANDEZ: Object.

You can answer.

A I think it falls within the expectation. I can't say it falls within a mandate because I don't know the scope of law for DOE well in terms of what its charge is in terms of its written mandates, but I do know that educational goals for young people is part and parcel to how Georgia wants kids to be well and thrive. So, yes, I consider that to be a part of how DOE wants kids to be well and thrive.

Q So you would consider services, behavioral health services for children enrolled in GNETS as part -- or a piece of the mission for the System of Care framework?

A For any kids, yes. But behavioral healthcare for any kids, yes.

Q Which includes kids in GNETS?

A Yes.

MR. HOLKINS: I know we're running out of time. I'd like to take a couple minute break to organize my material.

Can we take five minutes?

How much time do I have left?

THE VIDEOGRAPHER: You have 20 minutes.

Off record at 5:40 -- 6:40. Five.

(A recess was taken.)

THE VIDEOGRAPHER: Back on record at 5:42.

BY MR. HOLKINS:

Q Ms. Tiegreen, I'd like to ask just a couple more questions about the System of Care before changing gears.

Is it your understanding that the State of Georgia is required under state law to implement a System of Care framework?

MS. HERNANDEZ: Object.

You can answer.

A There is law about System of Care but I don't recall if the language says that we shall implement it.

So it talks about facilitating and bringing together state agencies and it talks about planning collaboratively, but I cannot recall the language precisely enough to answer that question in the affirmative or the negative.

Q Do you have any involvement in applying for System of Care grants from SAMHSA on behalf of the State of Georgia?

A I don't have any direct responsibility, but I would be kind of an informant to the process if one were going after or if we had an interest in making application, I would likely be a reviewer of that.

Q And have you reviewed an application on behalf of State of Georgia or a System of Care grant from SAMHSA?

A Many years ago, yes, but it's been a long time. Maybe, maybe the late -- I mean the early teens, maybe the last one I can recall.

Q Early 2010s?

A Yes.

Q Do you know whether there are, as a condition of receiving a System of Care grant from SAMHSA, requirements that the State implement a System of Care framework?

MS. HERNANDEZ: Objection.

You can answer.

A Generally states kind of set forth the goals of System of Care. I will just say from doing children's work for a long time that an actualized System of Care is aspirational, and not a definitive this is it and we're done.

And so I think in terms of if we made a commitment to the Feds, it would be some developmental goals towards advancing our work, but it wouldn't be, here, we're there, done, crossing the finish line.

Q So I'd like to shift gears now and ask you just a few questions about Apex, which is a program we discussed a few times today.

A Sure.

Q Apex is a mechanism for delivering school-based behavioral health services, correct?

A Apex is an initiative to promote the development of school-based mental health services, restating it the way I understand it.

Q I'd like to show you another exhibit, which will be 153. It has two parts, an email and attachment.

The email is Bates-stamped GA04292483.

(WHEREUPON, Plaintiff Exhibit-153 was marked for identification.)

BY MR. HOLKINS:

Q This is an email from you, dated February 11, 2020, with the title "Billing & Reimbursement Webinar Tomorrow," and attaching a PowerPoint presentation titled "Billing and Claims Improvement Opportunities 2020 Final."

Is that all accurate?

A Yes. Uh-hum.

Q I'd now like to shift to Part 2.

This is the presentation you attached, correct?

A It is.

Q For the record, this is GA04292485.001. The title of the document is Apex Billing & Claims Improvement Opportunities."

Did you give this presentation?

A I did.

Q To whom?

A To the Apex providers who are brought together by the Georgia State University Center of Excellence.

Q Is that all of the Apex providers at this time?

A They are invited. I don't know if everyone participated, but they are all invited.

Q And just to by clear, this is a presentation from February 2020, correct?

A Correct.

Q Have you given any presentations about Apex billing and claims since February of 2020?

A It feels like I might have done later in 2020 or either early in 2021. But I can't recall for sure.

Q Do you remember whether you used the same slide deck or whether you made updates to this presentation?

A I don't recall. It would have been fundamentally based on this, because we don't have significant -- we haven't had significant change in any of this content, but I can't say for sure.

Q Scrolling to Page 4, 5, and 6 of the presentation, I believe this is the entry in DBHDD's program manual for the Georgia Apex program?

A Uh-hum. (Affirmative.)

Q Is that accurate?

A That's accurate.

Q Do you know whether this entry has changed since you gave this presentation in February of

2020?

MS. HERNANDEZ: Objection.

You can answer.

A I can't say right off. The provider manual is so vast, I can't remember. We make adjustments to different program lines every quarter, so I can't speak with certainty without checking that document.

MR. HOLKINS: I'm just making note in the record to the extent that Ms. Tiegreen has given further presentations regarding Apex billing and claims, it would be responsive to the United States' request for documents, and we'll follow up to request that separately.

MS. COHEN: I see Danielle nodding her head, but I don't know if the record reflects her ascent.

MS. HERNANDEZ: I heard what he said.

BY MR. HOLKINS:

Q I wanted to show you another document which will be 153 -- give me a second. 154.

MS. COHEN: Give me that number.

MR. HOLKINS: 154.

MS. COHEN: Yeah.

MR. HOLKINS: Thank you.

(WHEREUPON, Plaintiff's Exhibit-154 was marked for identification.)

BY MR. HOLKINS:

Q I just produced what's been identified and introduced as Exhibit 154. This, for the record, is GA04278558.

There a number of emails in this chain, including an email from you dated October 8, 2019.

I'll give you a moment to review the document.

A Do I have -- thank you. I see the controls now.

(Witness reviews exhibit.)

A Okay.

Q So in your email, as I understand it, you're identifying an issue of Apex providers failing to bill Medicaid for billable services and instead relying on the DBHDD grant. Is that accurate?

A That is --

MS. HERNANDEZ: Objection of.

You can answer.

A Yes. So for the record, Dante has brought forth a list and some content of aspects where the providers have said we need to keep getting state

money because these things aren't reimbursable, and the pushback that I have provided here, where I say I'm perplexed, is content where if you look at the scope of what's in the Medicaid service description, I feel, as the writer, a lot of that service definition content, that these things actually are billable.

So a lot of times that comes down to perhaps a local clinical director feeling like something is not very medically oriented. They might have a real medicalized background and not think about recovery supports as being more flexible, more nontraditional and able to be implemented.

So these are items where I am saying back to the group, hum, I think these things are potentially still billable and it perplexes me that when providers say they're not, which is why then sometimes the COE periodically will bring me in to present on billing opportunities, such as were referenced in the last slides.

Q Are you aware of any analysis by DBHDD, systemwide, of under-billing for Medicaid billable services through Apex?

A There -- I wouldn't call it under-billing

necessarily. I would call it more conservative approach to the service parameters.

So the service has a range as defined in the provider manual, and there are occasions where provider agencies may say, I'm just not sure about that or I'm a little concerned if we do this that we might be audited and somebody might take that back because it's less traditional.

And so it is a push/pull between the flexibility and the policy and providers feeling like there are a variety of interpretations around this. And they also have other payors. The CMOs also are interpretive voices in their ear for some of this, which then can make them put themselves in a position of being like, well, if this CMO said this for our agency, let's implement in this more narrow pathway instead of this more broad one.

So I don't want to say that they're under-billing. I think the more fair representation is that they have varieties of approaches to content. Some may be more conservative, some may be more liberal when reading the policy.

Q So let's make this concrete. In this email you identify participation in IEP or 504 plans as a billable service?

A Uh-hum. (Affirmative.)
Q Is that accurate?
A Yes.
Q And some providers, based on your understanding, were not billing Medicaid for that service?
MS. HERNANDEZ: Objection.
You can answer.
Q Is that correct?
A I need to look at the detail.
Is there a particular line you're looking at to expedite my find?
Q So I'm looking here, your email dated October 8, 2019, where you write: "Some of the 'non-billable' items are things that I've consulted 'older' Apex providers on as billable. These items here still perplex me."
The first bullet is "Participation," if you scroll up, "in IEP or 504 plans."
A Hold on. I think my camera is blocking when I'm scrolling down between pages. I'm sorry.
THE VIDEOGRAPHER: Five minutes left.
A I see it now. I had the camera across -- the screen across the bottom.
Yes. So, again, as long as an IEP is

child centered, yes, participation can be billed via the service, community support.

Q Has DBHDD, to your understanding, undertaken any analysis of the full extent to which Apex providers are not billing for participation in an IEP or 504 plan?

A No --

MR. ROWLEN: Objection.

A -- we have not.

MS. HERNANDEZ: You can answer.

Q Is that likewise true for parent education, the next item identified?

A There's been no systematic analysis to what extent that is not being billed.

Again, we've provided TA after the fact of what parts can be billed, but we have not done a systematic analysis of where it is not being billed. That I'm aware of.

Q So very quickly, I wanted to show you one more document, which will be 155, Exhibit 155.

(WHEREUPON, Plaintiff's Exhibit-155 was marked for identification.)

BY MR. HOLKINS:

Q For the record, this is GA04225691.

Scrolling up, this is an email from you

dated January 7, 2018, to Dante McKay, cc'ing a number of recipients. The subject is "DCH, CMO Invitation to Peer Learning Event."

A Uh-hum. (Affirmative.)

Q I want to focus you on the text of your email, where you write: "Apex is a school-based behavioral health program, DBHDD pays for the infrastructure that Dante describes, and Medicaid (or other Third-party payers) cover the counseling, community support, nursing," et al.

Do you see that text?

A I do.

Q Can you expand on what you mean here, this distinction between paying for the infrastructure versus covering specific services?

A Sure. So when DBHDD enters into a contract for Apex, it is doing so in a developmental framework. So it is trying to create the motivation and the development of a community-based provider to go into the school, to build a relationship with the school, to integrate into the school culture, so that they can begin the process of delivering behavioral health supports and services within that school.

While they are kind of being -- they're

inculcating into that culture, there is not necessarily billing beginning. So we are paying for a lot of the developmental parts of relationship and for a lot of what's called nonproductive time in healthcare, where in a clinic you might have productivity of 50 percent. 20 hours a week of your 40-hour week has to be billable to like support your salary and the direct and indirect costs. That's how our rate is set.

When you go into a school system, it may be several weeks before you can achieve the amount of billing that would start to pay for salaries, or it could be several months before you're at that place.

So DBHDD is paying for this ramp-up of relationship and development that occurs, understanding sometimes that means attending a PTA meeting. That's not billable. It may be attending a school carnival on a Saturday, not billable.

But we want that practitioner to be available and accessible and seen as a trusted partner in that school. In that way, we are paying for kind of some infrastructure to build towards the ability to then really be actualizing, doing counseling, doing community support, doing nursing,

peer support, med management, and the like, and billing for that.

Q Is the expectation that once that relationship is built, Apex providers would be increasing the relying on Medicaid to fund services?

A Medicaid and other third-party payors, private insurance and the like.

Q What did you to prepare for this deposition today?

A We just had a brief orientation last week in terms of --

MS. HERNANDEZ: Don't -- sorry.

Don't say what we talked about but you can say we met.

A Yeah. We just met briefly on that and that's really the extent of it.

MR. HOLKINS: Okay. That's it.

Thank you very much for your time, Ms. Tiegreen.

THE VIDEOGRAPHER: We're off the record at 6:00 p.m.

(Whereupon, the deposition concluded at 6:00 p.m.)

C E R T I F I C A T E

STATE OF GEORGIA:

FULTON COUNTY:

I hereby certify that the foregoing transcript of WENDY W. TIEGREEN was taken down, as stated in the caption, and the questions and answers thereto were reduced by stenographic means under my direction;

That the foregoing Pages 1 through 282 represent typically a true and correct transcript of the evidence given upon said hearing;

And I further certify that I am not of kin or counsel to the parties in this case; am not in the regular employ of counsel for any of said parties; nor am I in anywise interested in the result of said case.

IN WITNESS WHEREOF, I have hereunto subscribed my name this 26th day of June, 2022.

Wanda L. Robinson

Wanda L. Robinson, CRR, CCR No. B-1973
My Commission Expires 10/11/2023

D I S C L O S U R E

STATE OF GEORGIA) VIDEOTAPE DEPOSITION OF
FULTON COUNTY) WENDY W. TIEGREEN - 6/21/22

Pursuant to Article 10.B of the Rules and Regulations of the Board of Court Reporting of the Judicial Council of Georgia, I make the following disclosure:

I am typically a Georgia certified court reporter. I am here as a representative of Esquire Deposition Solutions, LLC, and Esquire Deposition Solutions, LLC was contacted by the offices of U.S. Attorney's Office to provide court reporter services for this deposition. Esquire Deposition Solutions, LLC will not be taking this deposition under any contract that is prohibited by O.C.G.A. 9-11-28 (c).

Esquire Deposition Solutions, LLC has no contract/agreement to provide court reporter services with any party to the case, or any counsel in the case, or any reporter or reporting agency from whom typically a referral might have been made to cover this deposition.

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ERRATA SHEET FOR THE TRANSCRIPT OF:

Deponent Name: WENDY W. TIEGREEN

Case Caption: United States of America vs. State of Georgia

Case No. : 1:16-cv-03088-ELR

I do hereby certify that I have read all questions propounded to me and all answers given by me on the 21st day of June 2022, taken before Wanda L. Robinson, and that:

_____1) There are no changes noted.

_____2) The following changes are noted:

Pursuant to state rules of Civil Procedure and/or the Official Code of Georgia Annotated 9-11-30(e), both of which read in part: Any changes in form or substance which you desire to make shall be entered upon the deposition with a statement of the reason given for making them.

Accordingly, to assist you in effecting corrections, please use the form below:

CORRECTIONS:

Page	Line	Change	Reason For Change

CERTIFICATE OF DEPONENT

I hereby certify that I have read and examined the foregoing transcript, and the same is a true and accurate record of the testimony given by me. Any additions or corrections that I feel are necessary, I will attach on a separate sheet of paper to the original transcript.

_____

Signature of Deponent

I hereby certify that the individual representing himself/herself to be the above-named individual, appeared before me this _____ day of _____, 2022, and executed the above certificate in my presence.

_____

NOTARY PUBLIC

MY COMMISSION EXPIRES: